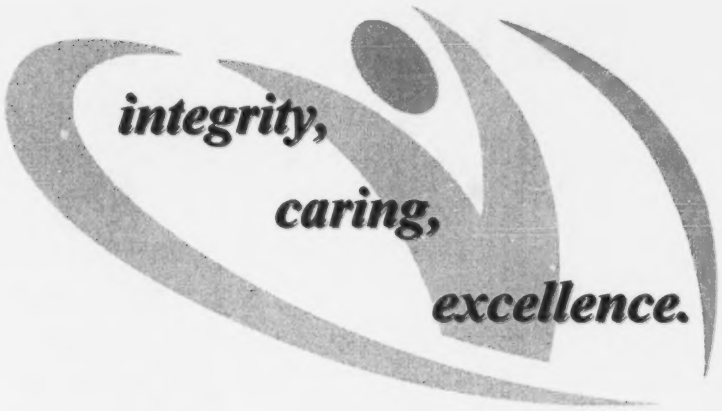
Regional Health Authority
Central Manitoba Inc.

Office régional de la santé
du Centre du Manitoba inc.

Annual Report
2004-2005

As the underlying set of core beliefs, our core values help to define our organization, guide our behaviour, underpin operational activity and shape the strategies we will pursue in the face of various challenges and opportunities. Influencing what we do, why we do it, and how we do it, they converge together to create the very fabric of the Regional Health Authority – Central Manitoba Inc. When placed in relationship to each other, our fundamental values of integrity, caring and excellence produce an unfolding of many other virtues or attributes.



To enjoy enduring success, we believe that our core values and purpose must hold firm even as our strategies and practices continually adapt to a changing environment. The development of our core purpose, our ENDs, is a reflection of ownership input and Board deliberation.

The Regional Health Authority – Central Manitoba Inc. exists so that people in our Region are as healthy as they can be at a reasonable cost to the community.

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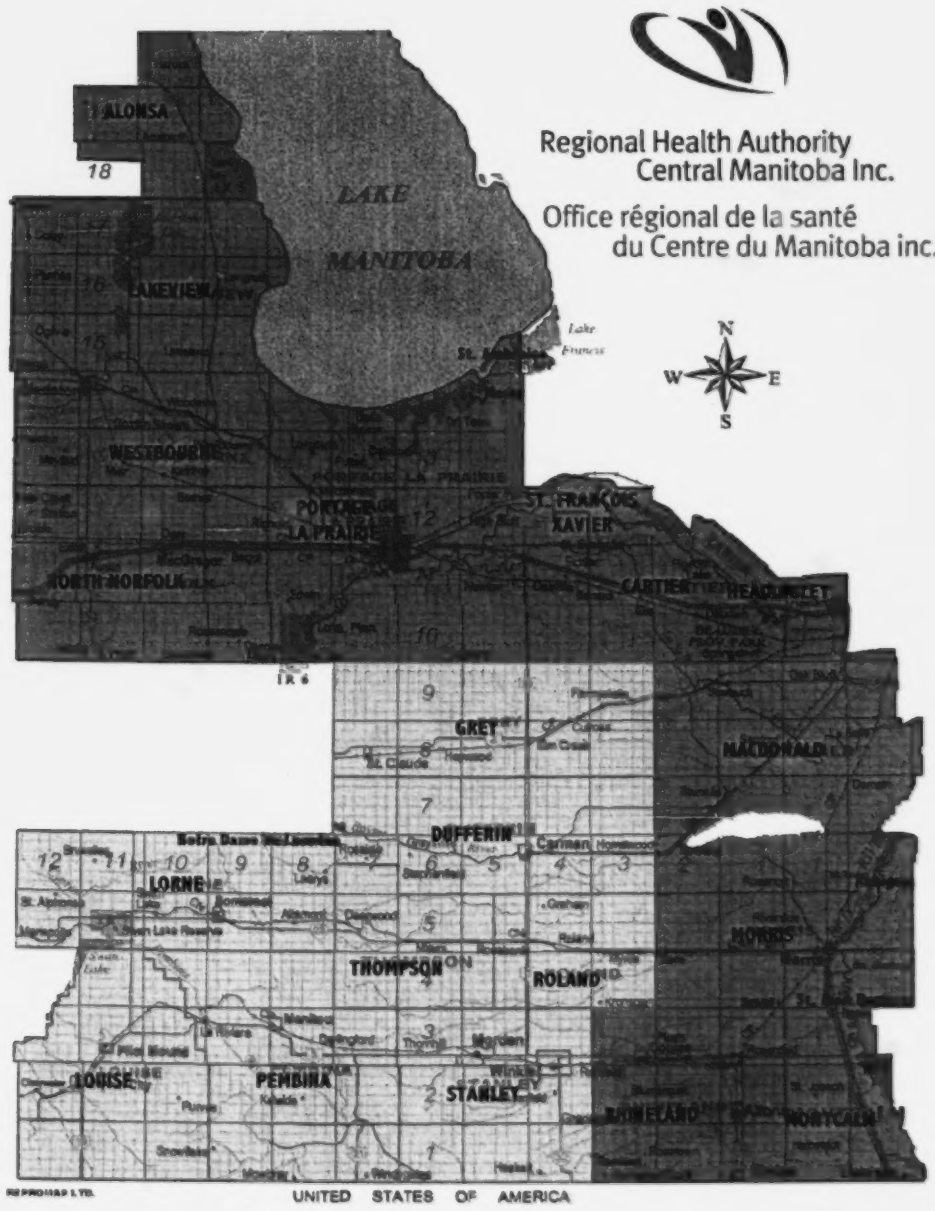
An abridged copy of this report is available in French upon request from the Regional Health Authority – Central Manitoba Inc.

La version française (abrégée) du rapport annuel est disponible sur demande au bureau de l'Office régional de la santé du Centre du Manitoba inc.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CENTRAL REGION

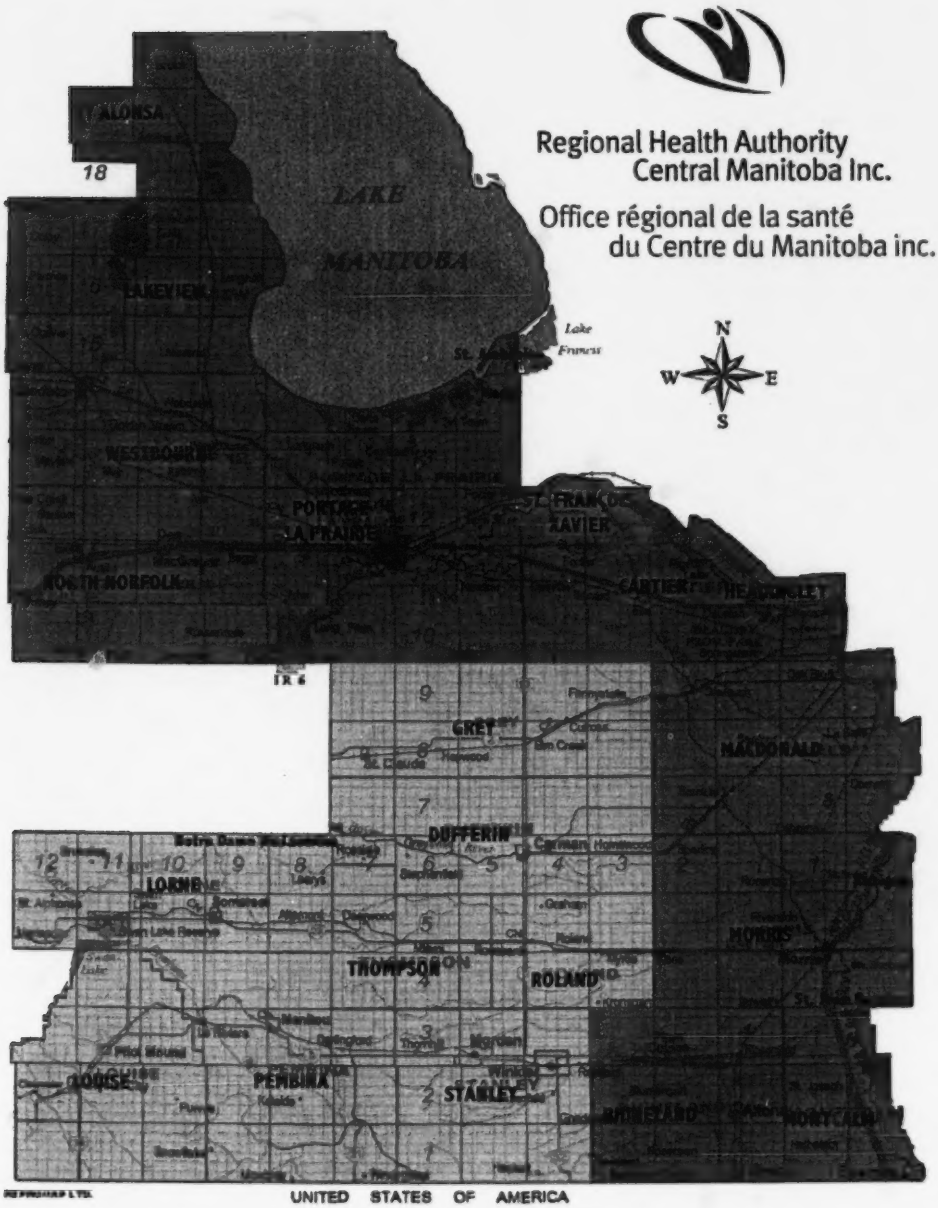
Set against a backdrop of rolling hills and rivers in southern central Manitoba, the Regional Health Authority – Central Manitoba Inc. *(RHA Central or Central Region)* extends over 18,500 square kilometres from the western edge of the Pembina Valley to the Red River in the East. It expands from Lake Manitoba in the North to the International border in the South with the Trans Canada Highway crossing it horizontally.

The most recent population estimate available for the Central Region from Manitoba Health is for June of 2001 and it indicates that the population was 98,271. RHA Central has the largest population of all the rural and northern RHA's and is second only to Winnipeg in population.

The population of the Central Region has changed more than the population of Manitoba overall. The population of RHA Central increased 2.6% between the 1996 and 2001 Census while in the province overall, the population increased just 0.5%. According to the Manitoba Health Regions Population Projections (1998-2025) document prepared by the Manitoba Bureau of Statistics in 1999, the population of Central Region is expected to increase by a total of 14.5% between 1998 and 2025.

According to the 2001 Census, the median age of the RHA Central population was 35.0, just slightly younger than 36.8 years old for the province. For males born in 1998, life expectancy was 75.7 and, for females, it was 80.7. (Manitoba Bureau of Statistics, Population Projections document).

RHA Central has a fairly diverse population in terms of languages. Over one quarter (27.2%) of RHA Central residents indicated that their first language (and still understood) was a language other than English or French. This is higher than the provincial rate of 21 per cent of residents.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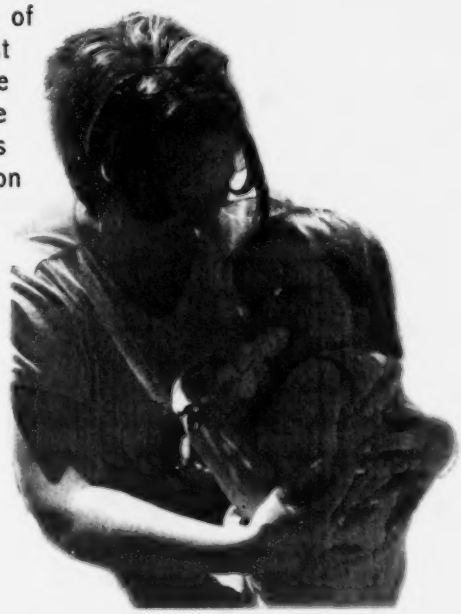

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BOARD OF DIRECTORS

JOHN KRAHN, Chair
(Winkler)

GÉRALD LEMOULLEC, Vice-Chair
(Notre Dame de Lourdes)

CÉLINE BEAUDETTE
(St. Jean Baptiste)

KELLY BEAULIEU
(Portage la Prairie)

ERIC CAMERON
(Swan Lake)

RALPH CIBULA
(Gladstone)

TED FRANSEN
(Morden)

CONNIE GRETSINGER
(Portage la Prairie)

ROGER KIROUAC
(La Salle)

JEANNIE MARION
(Morris)

BOB MCKENZIE
(Carman)

JOANNE ROULETTE
(Marius)

ALBERT SCHMIDT
(Altona)

DAREN VANDENBUSSCHE
(Portage la Prairie)

SHERYL FELLER, (Sanford)
Past Board Member

DISTRICT HEALTH ADVISORY COUNCIL

TRAVIS LONG, CHAIR	Manitou
MARGE FRIESEN, VICE-CHAIR	Altona
ANDRÉ DACQUAY	Notre Dame de Lourdes
MARJ HEINRICHS	Rosenort
JACOB HILDEBRAND	Halbstadt
LYNN KAUPPILA	Elie
HENRIETTA KLEEMOLA	Langruth
CAROLYN KOSTAL	Headingley
CHERYL MCKITRICK	Crystal City
MABEL MCKNIGHT	Roland
THOMAS MUIR	Portage la Prairie
LAWRENCE POW	Emerson
LESLIE TITCHKOSKY	Morden
JACK WIEBE	Winkler
GWEN WISHART	Gladstone

MEDICAL ADVISORY COMMITTEE

The Chiefs of Staff from each medical group meet together regularly to monitor reports and to provide direction about medical practice issues, be the standards, pharmacy and therapeutics, diagnostics, medical staff by-laws or reviewing credentials and recommending privileges to the Board.

DR. DENIS FORTIER, CHAIR
DR. EVA BERMAN WONG
DR. HAROLD BOOY
DR. SHELLEY BUCHAN
DR. KATHY FUNK
DR. DAN GERBER
DR. DAVID KINNEAR
DR. ROBERT KRUK
DR. ANN LOEWEN
DR. ENOK PERSSON
DR. SANDOR VOROS

Dr. Denis Fortier
Regional Chief of Staff

John Krahn
Chairperson

Honourable Tim Sale
Minister of Health

Dear Minister Sale:

I am honored to present the Annual Report of the Regional Health Authority – Central Manitoba Inc. (RHA) for the fiscal year ended March 31, 2005. The document was prepared under the direction of the Board of Directors in accordance with the Regional Health Authorities Act and direction provided by the Minister of Health. All material, economic and fiscal implications known as of September 2, 2005, have been considered in preparing the annual report.

Our most fundamental obligation as a Board is to act as the voice of our ownership – the residents of Central Region. On their behalf, we established our core purpose and long-term vision: "The Regional Health Authority – Central Manitoba Inc. exists so that people in Central Region are AS HEALTHY AS CAN BE at a reasonable cost to the community." We remain firmly dedicated to this END. In so doing, we remain diligent in pursuing Ownership Linkage opportunities. In 2004, we planned and had meetings with specific communities such as Long Plain First Nation and Montcalm seniors. The Board continues designing linkage activities targeting priority populations.

Following the 2004 Community Health Assessment, children were identified as the highest priority group. The Board accordingly mandated some of its members to link with youth in high schools in Central Region, to gain a better insight into their perceptions/attitudes regarding health matters. Students were asked what it means to be healthy, what they identify as health issues, what barriers exist and what the Regional Health Authority should be doing to help people become healthy.

A document incorporating the issues identified by the students along with information contained in the 2004 Community Health Assessment was prepared and presented to the Healthy Kids, Healthy Futures All-Party Task Force in March, 2005, in Winnipeg.

Recommendations to the Task Force included more programming options on injury prevention, healthy lifestyle, leadership development opportunities for students, better access to mental health services for children and youth, culturally appropriate programming material and increased supports for parents/guardians in fostering the health and development of their children.

The Board is proud of the work achieved on this project and appreciative of the positive contribution of students and schools in this undertaking. We have already seen some encouraging outcomes with the release of the Healthy Kids, Healthy Futures Task Force report, which reflects our combined strategies to "help create the necessary conditions that support our efforts to promote healthy living for children and youth".

As well as setting the overall long-term direction of the RHA Central through the ENDs development process, the Board of Directors is responsible for overseeing the ethical conduct of the organization. The most visible embodiment of an organization's ethical conduct is expressed through its core values - essential tools for making judgments, assessing probable outcomes of intended actions, and choosing among options. In September, the Board identified the underlying set of core beliefs that should define our organization, guide our behaviour and shape the strategies we pursue in the face of various challenges and opportunities.

Integrity. . .Caring. . .Excellence.

Influencing what we do, why we do it, and how we do it, we hope these values will converge together to create the very fabric of the Regional Health Authority – Central Manitoba Inc.

Living our core values is a process that imparts truth to the choices we make. To demonstrate integrity, caring and excellence and improve the quality of its governance practices, the RHA Central Board routinely assesses its performance. In this regard, the Board regularly reviews all policies and monitors progress and compliance. For example, in 2004, in addition to examining all of its policies, the Board considered and amended bylaws to reflect current legal requirements. The Board also explored some elements of "evidence-based" decision-making. At its spring workshop, the Board gained a greater understanding of what constitutes evidence, and what prevents change from taking place when there is clear evidence that it is necessary and desirable.

Furthermore, in early March, 2005, the Board had an opportunity to dialogue with the Minister of Health, the Honorable Tim Sale, about health challenges and opportunities in RHA Central and in the Province. Authority, accountability and responsibility of Board members, current funding levels, human resources and capital resources such as buildings and information technology were topics of discussion.

Last year, I reported the Board's efforts in lobbying for the development of a rural RN diploma program. We solicited and received remarkable support from municipalities, foundations and other stakeholders in the Region. We were very happy when Premier Gary Doer announced the start of a diploma nursing program at Portage la Prairie, Winkler and Dauphin. In May, 2005, Red River College began operating the program allowing licensed practical nurses to receive their registered nurse designation.

The Board has ultimate oversight for the successful performance of the organization. It discharges this duty by delegating operations to the Chief Executive Officer (CEO) and holding him accountable for organizational achievement. Balancing the demand for new programs to pursue Board ENDs and to meet emerging needs in the context of diminishing resources is a constant challenge. We are grateful to our CEO Neil Walker for his wisdom and insight this past year and acknowledge his tireless efforts in leading the organization through a difficult but successful transition.

We would also like to congratulate the entire staff, physicians and volunteers for their successes during the year and recognize their professionalism and devotion. In spite of a demanding environment and constant pressures, we are able to witness their Integrity, Caring and Excellence.

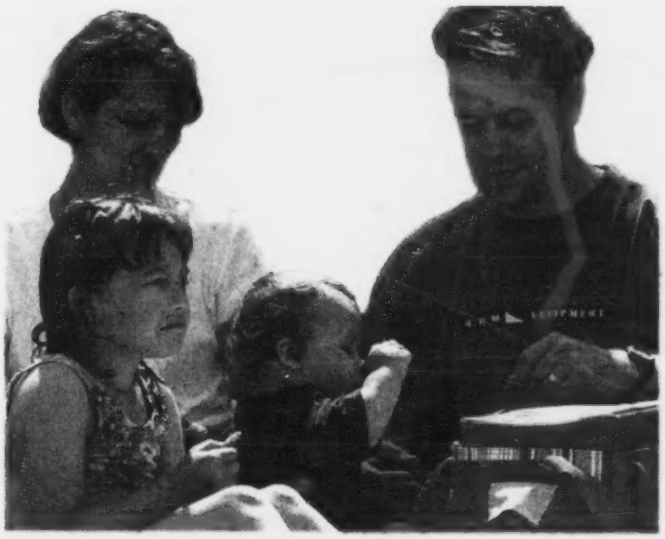
More than ever, Board members are expected to make stronger commitments in terms of time, accountability, and ongoing education. For these reasons, I would like to commend them for their dedicated service in the past year. This group of talented individuals has worked assiduously as an engaged, cohesive team with a transparent and open approach. After having fulfilled two consecutive terms and six years of generous personal involvement with the RHA Central, Sheryl Feller

retired from the Board. We thank Sheryl for her many contributions. Her acumen and her skills in facilitating our discussions will be missed. We would also like to welcome new director Daren VanDenBussche from Portage la Prairie.

The gap between today's reality and the achievement of our vision of people in Central Region being "AS HEALTHY AS CAN BE" may seem overwhelming. However, the obvious disparity only strengthens our convictions and inspires us to work harder for its attainment. We are grateful to the regional Medical Advisory Committee, the community and the District Health Advisory Council for joining us on the journey ahead to make it happen. Your involvement and your support are the key ingredients to our continued success and have been invaluable in guiding the Board in its job.

Respectfully submitted on behalf of the
Regional Health Authority – Central Manitoba Inc.

John Krahn
Chair



BOARD ENDS – STATEMENT OF PURPOSE

April 28, 2004

The Regional Health Authority – Central Manitoba Inc. exists so that people in our Region are as healthy as they can be at a reasonable cost to the community.

A. We interpret people to be INDIVIDUALS who are as healthy as they can be. In order of priority, this includes, but is not limited to:

A.1 INDIVIDUALS are aware of and demonstrate healthy lifestyle behaviours.
- A.1.1 INDIVIDUALS experience physical wellbeing
  - A.1.1.1 Individuals are free from preventable illness, death and injury
  - A.1.1.2 Individuals have healthy weights.
- A.1.2 INDIVIDUALS experience emotional, spiritual & social wellbeing
  - A.1.2.1 Individuals have healthy relationships
  - A.1.2.2 Individuals experience healthy family environments
  - A.1.2.3 Individuals perceive a supportive network within their community.

A.2 INDIVIDUALS have a safe environment.
- A.2.1 Individuals have safe physical environments where they work and live
  - A.2.1.1 Individuals have safe water supplies
  - A.2.1.2 Individuals breathe healthy air.

A.3 INDIVIDUALS in need of health care experience a timely return to their optimal health.
- A.3.1 Individuals receive appropriate care
- A.3.2 Individuals are treated with dignity.

B. We further interpret individuals to include, in order of priority, the following groups: CHILDREN, ABORIGINALS, WOMEN, MEN and SENIORS.

B.1 CHILDREN are as healthy as they can be. In order of priority this includes, but is not limited to:
- B.1.2 Children have healthy growth and development
  - B.1.2.1 Children do not die in infancy
  - B.1.2.2 Children remain free from preventable death or injury
  - B.1.2.3 Children are protected from communicable diseases
  - B.1.2.4 Children are physically active
  - B.1.2 5 Children practice healthy eating.
- B.1.3 Children are born without and remain free from the harmful effects of tobacco, alcohol, drugs and solvents.
- B.1.4 Children have responsible and effective guardianship.
- B.1.5 Children have high levels of self-esteem.
- B.1.6 Children make age-appropriate and culturally appropriate lifestyle choices.
- B.1.7 Children have access to the highest educational attainment.
- B.1.8. Children feel safe in their environment.

B.2 ABORIGINALS, including First Nations, Métis and Inuit, are as healthy as they can be. In order of priority, this includes but is not limited to:

- B.2.1 Aboriginals live at least as long as other people in Central Region
  - B.2.1.1 Children and adolescents practice healthy lifestyle behaviours
  - B.2.1.2 Aboriginals will not die from complications of diabetes.
- B.2.2 Aboriginals have hope and pride and dignity
  - B.2.2.1 Aboriginals receive psychosocial support in situations that diminish their hope, pride and dignity.
- B.2.3 Aboriginals receive the services they need despite jurisdictional barriers
  - B.2.3.1 Aboriginals live in a healthy environment.
- B.2.4 Aboriginals receive culturally appropriate health care.

B.3 WOMEN are as healthy as they can be. In order of priority, this includes but is not limited to:

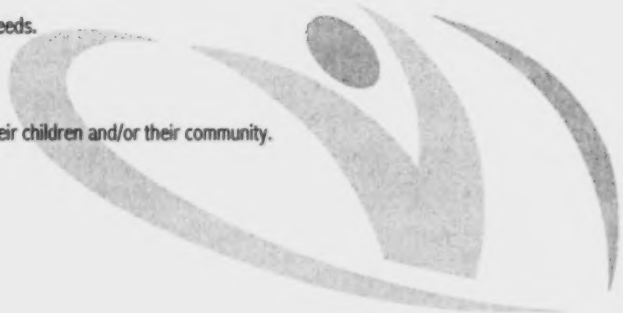
- B.3.1 Women have safe living and working conditions
  - B.3.1.1 Women are free from violence
  - B.3.1.2 Women have sufficient financial resources.
- B.3.2 Women have good reproductive health.
- B.3.3 Women are supported in their care-giving role.

B.4 MEN are as healthy as they can be. In order of priority, this includes but is not limited to:

- B.4.1 Men do not suffer or die from preventable injuries
  - B.4.1.1 Men will make informed choices related to high-risk activities.
- B.4.2 Men will have good mental health.
- B.4.3 Men are free from addictions.
- B.4.4 Men are educated and employed to their full potential.
- B.4.5 Men will access services when they need them.

B.5 SENIORS are as healthy as they can be. In order of priority, this includes but is not limited to:

- B.5.1 Seniors remain independent and active as long as possible.
- B.5.2 Seniors experience an optimal quality of life
  - B.5.2.1 Seniors are free from abuse.
- B.5.3 Seniors live in their community of choice
  - B.5.3.1 Seniors utilize housing appropriate to their needs.
- B.5.4 Seniors have support in their care-giving role.
- B.5.5 Seniors receive respect and appropriate care from their children and/or their community.



Neil Walker
Chief Executive Officer

Mr. John Krahn, Chair
Regional Health Authority – Central Manitoba Inc.

It is my pleasure to present the Regional Health Authority – Central Manitoba Inc.'s annual report for 2004-2005. Having completed my first full year as Chief Executive Officer, I am distinctly proud of working with an exceptional group of highly skilled and committed people and being part of a dynamic, future-focused organization.

In my first annual report to the Board of Directors last year, I spoke of our organization in transition. While striving to provide local accountability and integration along the continuum of care in the context of regional standards and practices we undeniably succeeded in implementing area leadership and program management. Is the transformation complete? The difference is already palpable. We have set in motion a process that has created new confidence throughout the organization and the momentum is strong. Our course is well charted:

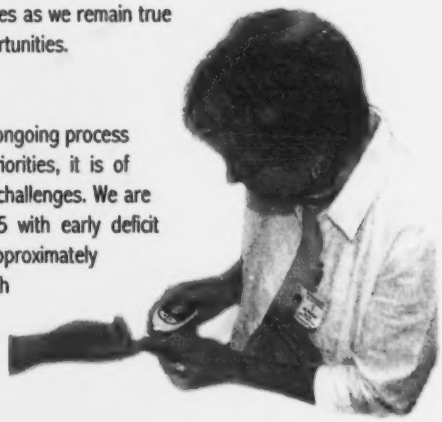
Our core values --Integrity, Caring and Excellence-- define who we are, what we are about. They steer and fuel our progress.

Our Board END --so that people in our Region are AS HEALTHY AS THEY CAN BE at a reasonable cost to the community - identifies why the organization exists and what difference it will make to the residents of Central Region. It is our destination and it is the Board's clear assignment to the staff.

Our four strategic pillars support staff in determining our programs and services and in achieving our Board ENDs:

- Organizational Responsiveness through an Integrated Health System
- Healthy Worklife through a Healthy Workplace
- Building Capacity with Clients and Community through Partnerships
- System Competency through Performance Improvement.

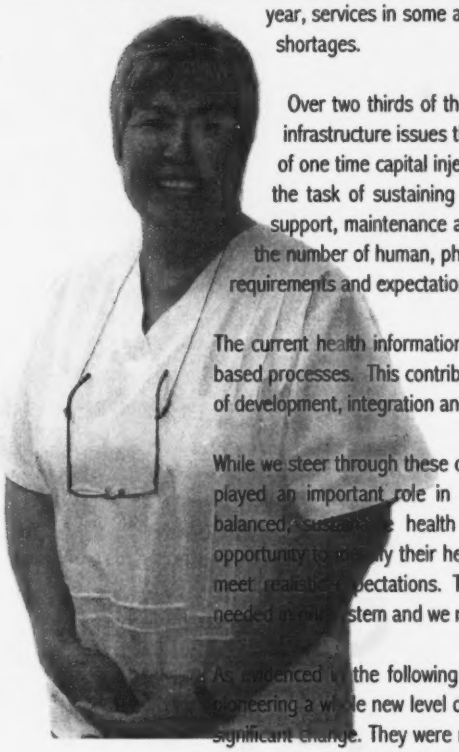
In the months and years ahead, we'll focus on leveraging these strategies as we remain true to our core values and purpose and as we face new challenges and opportunities.



Our Challenges

We expect continued cost pressures. While we have been involved in an ongoing process of realignment of resources to more effectively respond to Board priorities, it is of paramount importance that we find new ways to excel in spite of fiscal challenges. We are an efficient and effective organization. Although we entered 2004-05 with early deficit projections of over $4M, we managed to end the year with a deficit of approximately $1.2M. The prevailing budget concerns will continue to test our strength and resolve. With limited scope for short-term reductions, we must take care in maintaining our core infrastructure so fundamental programs remain viable and available. Yet we must also make strategic investments to fulfill our responsibilities in the community.

Recruitment and retention of health care professionals continues to be a challenge – specifically nurses, audiologists, pharmacists and lab and radiology technologists. The workforce is ageing and more staff are eligible to retire. The challenge is to continue maintaining services in some areas, particularly during holiday and vacation times. During the year, services in some areas have had to be curtailed for intermittent periods of time due to staff shortages.



Over two thirds of the sites within Central Region still have major information technology (IT) infrastructure issues that affect their ability to deliver services. Funding continues to be a series of one time capital injections rather than ongoing capital and operation investment. This makes the task of sustaining the IT infrastructure and applications difficult at best. The numbers of support, maintenance and projects waiting attention continue to grow. This is a direct result of the number of human, physical and financial resources as compared to the current level of service requirements and expectations.

The current health information system is a mixture of isolated electronic-based and obsolete manual-based processes. This contributes to an information-sharing environment that is desperate and in need of development, integration and in some instances replacement.

While we steer through these challenges, we also see many opportunities. Our communities have always played an important role in building and sustaining health services. As we work to build a more balanced, sustainable health system, we partner with our communities to ensure they have an opportunity to identify their health needs and are involved in determining how we will work together to meet realistic expectations. Their input and collaboration is important for supporting the changes needed in our system and we recognize the need for strong, ongoing dialogue with stakeholders.

As evidenced in the following pages, our reorganization has yielded many accomplishments. We are pioneering a whole new level of excellence. The staff, physicians and volunteers were willing to embrace significant change. They were more closely involved in our strategic planning than ever before and they made a great contribution. Their dedication, support and tireless efforts are not easily measured on a balance sheet however they are reflected in all our successes.

I would also like to acknowledge the leadership, advocacy and guidance of our Board of Directors. Through its work on core values and Board ENDs, the Board has truly energized and inspired the entire organization. Quality health care goes far beyond efficiency and productivity. As our plan materializes, our focus will remain firmly imbedded in the core ideology established by the Board.

The RHA Central is blessed with people and communities who are willing to collaborate and participate. The strategic plan is indeed inspired from stakeholder input and with the creative work of many people. From the Community Health Assessment in 2003-04 to ongoing consultations and board linkage activities, community input is evident in our strategies and actions to accomplish the Board ENDs. This legacy gives us the mandate by which to advance changes that honor our core values of integrity, caring and excellence.

Respectfully submitted,

Neil Walker
Chief Executive Officer

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Central Manitoba Inc.

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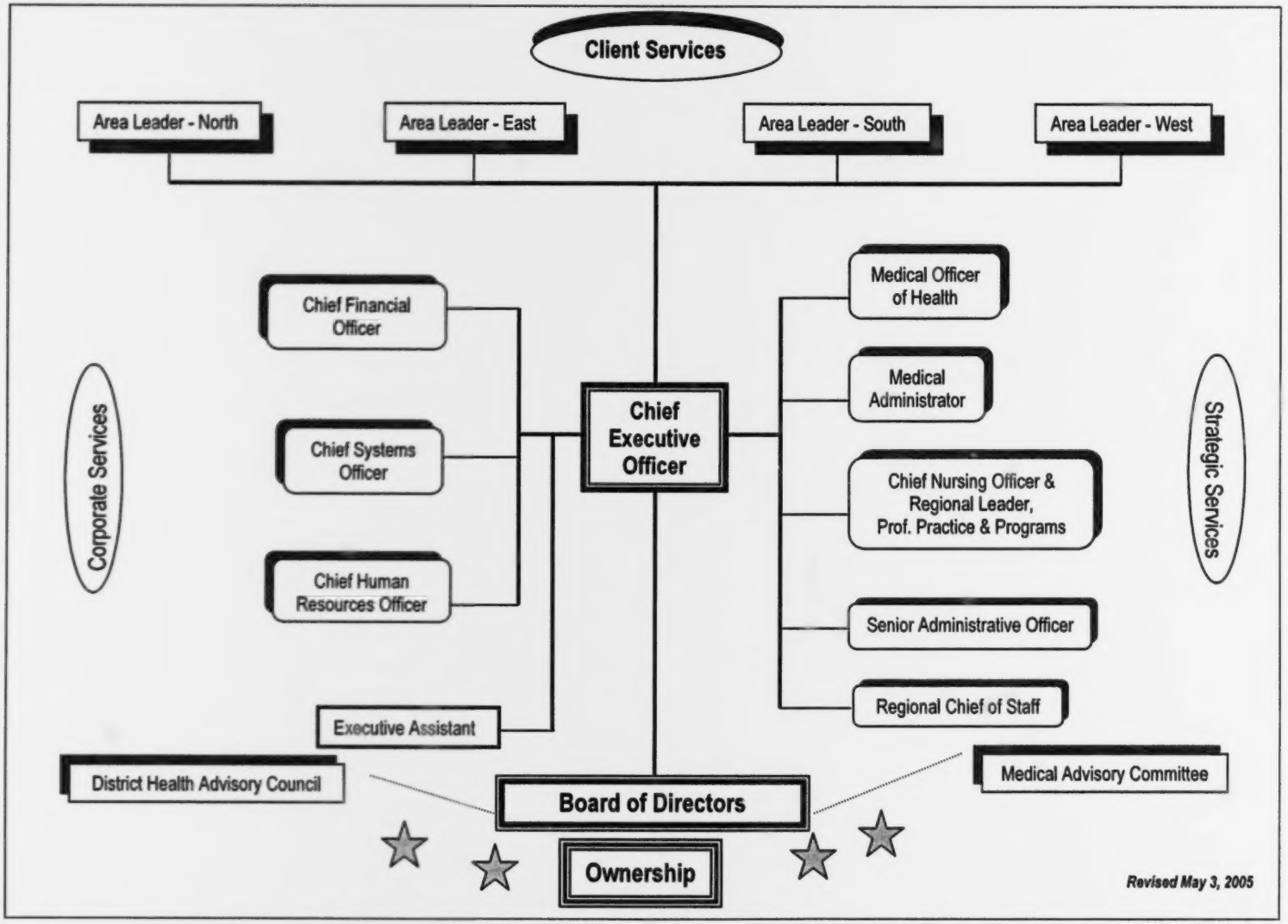


MANAGEMENT

NEIL WALKER	Chief Executive Officer
KEN KLASSEN	Chief Financial Officer
CLAUDETTE LAHAIE	Senior Administrative Officer
DR. SHELLEY BUCHAN	Medical Officer of Health
MARTIN MONTANTI	Chief Systems Officer
JIM HUNTER	Chief Human Resources Officer
HELMUTH KLASSEN	Medical Administrator
DEBBIE NELSON	Chief Nursing Officer & Regional Leader, Professional Practice and Programs
DR. DENIS FORTIER	Regional Chief of Staff
CAROL HILDEBRAND	Area Leader – East
WINNIE PAUCH	Area Leader – North
LORINDA SCHRAMM	Area Leader – South
JACQUELINE THÉROUX	Area Leader – West

PROGRAMS/SERVICES LEADERS

ABORIGINAL SERVICES - Jennifer Baker

BUDGETING/AUDITS - Dale Jamieson

CHILD & ADOLESCENT HEALTH - Jane Curtis

CORPORATE COMMUNICATIONS - Lorraine Grenier

CRITICAL CARE/MEDICINE /SURGERY - Eileen Vodden

DIAGNOSTIC SERVICES - Mark Anderson

EMERGENCY PREPAREDNESS/EMERGENCY MEDICAL SERVICES - Larry Skoglund

FRENCH LANGUAGE SERVICES - Lorraine Grenier

HEALTH INFORMATION - Shelley Barnes

HEALTHY LIVING - Jane Curtis

HUMAN RESOURCES

- Human Resources Officer – Cindy Joel
- Occupational Health & Safety – Bev Wood
- Aboriginal Recruitment & Retention – Jessica Selby

INFORMATION TECHNOLOGY - Shaun Twist

LABOUR RELATIONS - Ardith Rothwell

MENTAL HEALTH - Jan Marie Graham

NUTRITION & FOOD SERVICES - Jane Curtis

PALLIATIVE CARE - Jan Marie Graham

PAYROLL - Sheldon Hildebrand

PHARMACY SERVICES - Shawn Bugden

PHYSICAL RESOURCES & ENVIRONMENTAL SERVICES/WORKPLACE HEALTH & SAFETY/ SECURITY - Terry Hills

PRIMARY HEALTH CARE - Jennifer Baker

QUALITY IMPROVEMENT/RISK MANAGEMENT - Kristine Svendsen

REGIONAL REHABILITATION - Philippa Gerbrandt & Patti Mendarozqueta

SENIORS' HEALTH - Bev Boyd

SPECIAL PROJECTS - Carol Garnham

STAFF DEVELOPMENT - Kim Dyck

WOMEN'S HEALTH - Mary Smith

COMMUNITY LEADERS

EAST	Altona	**Community Integrated Health Services Leader** – Edith Calder *Altona Community Memorial Health Centre*
	Emerson	**Community Integrated Health Services Leader** – Paulette Goossen *Emerson Health Centre*
	Morris	**Community Integrated Health Services Leader** – Brad Street *Morris General Hospital* *Red River Valley Lodge*
	Rosenort	**Community Integrated Health Services Liaison** – Grace Klassen
NORTH	Gladstone	**Community Integrated Health Services Leader** – Dorothy Doell *Seven Regions Health Centre* *Third Crossing Manor*
	MacGregor	**Community Integrated Health Services Leader** – Sharon Stewart *MacGregor Health Centre*
	Portage	**Integrated Client Services Leader (Acute, Mental Health & Public Health)** – Pat Nodrick **Integrated Support Services Leader (Portage)** – Terry Hills **Portage Seniors' Integrated Client Services Leader** – Bev Boyd *Douglas Campbell Lodge* *Lions Prairie Manor* *Portage District General Hospital*
SOUTH	Crystal City/ Pilot Mound	**Community Integrated Health Services Leader** – Pam King **Prairie View Lodge* ** Rock Lake Health District Hospital* ** Rock Lake Health District PCH*
	Manitou	**Community Integrated Health Services Leader** – Sandra Dobson *Pembina Manitou Health Centre*
	Morden/Winkler	**Integrated Client Services Leader** – Linda Buhr **Interim Integrated Support Services Leader** – Sandra Dobson *Boundary Trails Health Centre* **Tabor Home Inc.* ** Salem Home Inc.* ** Eden Mental Health Centre*
WEST	Carman	**Community Integrated Health Services Leader** – Julie Hesketh *Carman Memorial Hospital* *Boyne Lodge*
	Notre Dame	**Community Integrated Health Services Leader** – Cheryl Harrison *Foyer Notre Dame* *Notre Dame Hospital*
	St. Claude	**Community Integrated Health Services Leader** – Mona Spencer *St. Claude Health Centre (Hospital/Pavilion)*
	Swan Lake	**Community Integrated Health Services Leader** – Kristal McKitrick-Bazin *Lorne Memorial Hospital*

* CONTRACT HEALTH CORPORATIONS

THE YEAR IN REVIEW

OUR PERFORMANCE STORY: ACHIEVEMENT OF GOALS

"A journey of a thousand miles begins with a single step."
Confucius

Last year, we reported early progress in transforming our organization with the implementation of area leadership and program management. Our goals were:

1. Greater integration along the continuum of care as part of a regional health system;
2. Accountability, responsibility and integration at the local geographic level as well as at the regional level;
3. A structure supporting community identity with local administrative leadership;
4. A structure that will be ready to respond to future fiscal and human resource challenges and is essentially cost neutral;
5. More rapid decision-making at the service delivery level based on corporate/regional policy and standards of practice;
6. Best practice and high standards of professionalism.

HOW DID WE DO?

Goal 1: Greater integration along the continuum of care as part of a regional health system

- ✓ Area Leadership now prepares operational plans for flu campaign and expanded immunization program through public health offices. New statistical data collection system was implemented.
- ✓ Community services leadership and financial reporting for public health, mental health, home care, environmental services and health information services were deployed to Areas in April, 2004. Emergency medical services, staff development and services to seniors were deployed in October, 2004.
- ✓ Long term care (LTC) facilities now implement regional admission documentation and care plans as per LTC Committee recommendations.
- ✓ Emergency room client identification band system was implemented regionally.
- ✓ Emergency medical services are integrating with acute care services by assisting on wards and with lab/imaging services.
- ✓ The International Classification of Disease and Related Health Problems (ICD10) an internationally recognized coding standard for determining patient diagnosis, was implemented in the province of Manitoba with the processing of April 1, 2004 discharges.
- ✓ Through process improvement, an automated information technology (IT) network monitoring tool was implemented; initial phases of the support model were put in place; the IT requisition, purchase and product positioning process was streamlined and resources were moved closer to the areas to help support the new organizational structure.
- ✓ The core of the Virtual Private Network (VPN) security structure was put in place to allow secure wide area network access across the major facilities within the Region. As well the system was architected to allow access via Private Data Network (PDN), internet and Remote Access Services (RAS) dial up.

- ✓ A standardized data collection form and referral form was developed for use at Pre-school Wellness Fairs throughout the Region.
- ✓ Pharmacy services produce a newsletter for the staff of the Region on issues related to proper and safe use of medication (Fentanyl Patch Use, Probenecid for Outpatient Antibiotics, Oral use of Vitamin K).
- ✓ Emerson Health Centre RN Job Description was revised to focus on primary health service delivery.
- ✓ In January, 2005, a Speech Language Pathology Outreach Program was established in the Manitou community in partnership with the local Day Care program.
- ✓ Integration of Staff Initiatives have been accomplished through staff appreciation barbecues and staff recognition awards.
- ✓ Implemented dysphagia program at all long term care (LTC) facilities.
- ✓ Fall prevention strategy was developed and trialed in Altona LTC and Carman LTC.
- ✓ New long term care facility Orientation Package was developed.
- ✓ Staff educators no longer concentrate on just one site but also attend other sites within the areas related to their focus of expertise, i.e. infection control, seniors.

Goal 2: Accountability, responsibility and integration at the local level as well as regional level.

Organizational "Core Values" were developed by the Board and the Organization Leadership Team.

- ✓ Regional Integrated Health System Teams are now structured to include Medical Leaders and Area Program Specialists from each of the four Areas in the Region. Teams are responsible for ongoing health assessment, planning, evaluation, continuous quality improvement, risk management, policy and practice standards, utilization, performance deliverables and providing monitoring on the applicable Board ENDs and Executive Limitations.
- ✓ Board ENDs were cascaded throughout the organization and program teams developed Reasonable Interpretations of the Board work.
- ✓ A two-day education session on ethics was held with Peter Allatt, Clinical Ethicist. This was followed by the roll out of Research Ethics Review Process and the roll out of a Framework for Ethical Decision-Making
- ✓ A Finance Function Review led to development of a five-year plan for the finance area.
- ✓ A budget framework and process was developed and implemented. The budget process involves the whole organization and focuses accountability at the local level.
- ✓ New chart of accounts were developed and implemented to support the organizational changes.
- ✓ Throughout the year, health promotion staff provided information on injury prevention through attendance at Pre-School Wellness Fairs, Farm Safety Days and articles in local and regional newspapers and publications.

- ✓ A number of information technology infrastructure project were undertaken and successfully completed, these include Foyer Notre Dame Inc., Notre Dame Hospital, Pembina Manitou Health Centre, Montcalm Health Centre, St. Claude, Altona and Morris Community (Morris Hospital, EMS and Red River Valley) 25 Tupper in Portage la Prairie and Portage District General Hospital.

- ✓ A number of regional applications were centralized out of the Portage District General Hospital. These include Momentum Financials, Momentum Material Management, Momentum Dietary and ESP. Salem Home Inc. implemented a long term care application that is housed centrally out of Portage District General Hospital.
- ✓ Space was acquired, in conjunction with the Computed Tomography (CT) addition at the Portage District General Hospital, to build a server room that will be the beginnings of a regional level data centre.
- ✓ Planned Evacuation (Flood) Disaster Manual was reviewed and revised by the East Area Leadership Team.
- ✓ Since the reorganization, the communication process has improved with:
    - o the development of organization charts
    - o regular team meetings and
    - o encouraging staff to submit articles to the regional staff newsletter, the "As a matter of Fact" and the "*Healthy As Can Be*" newsletter.
- ✓ Photo Identification Badges now identify staff by name and designation, as part of the RHA health delivery team. This identification allows all personnel to better understand their role as part of a bigger picture.

Goal 3: A structure supporting community identity with local administrative leadership

- ✓ Community Integrated Health Services Leaders (CIHSL) now function as community leaders and establish relationships with local Foundations, Health Boards and Auxiliary Groups.
- ✓ Area Program Specialists from each Area collaborate on regional teams.
- ✓ Collaboration Agreement template was developed for working agreements with Family Resource Centres and Community Groups.
- ✓ Risk Factor and Complication Assessment (RFCA) tools have been developed, including the development of a Regional RFCA Flowsheet and Regional Diabetes Care Record for use in the RFCA clinics. The RHA community of Gladstone and the First Nation community of Sandy Bay were trained in the competencies of RFCA. A total of 13 staff were trained from these two communities. In February, 2005, a second Regional Training Team was developed and trained at the Diabetes Education Network (DEN).
- ✓ Sandy Bay First Nation and Amaranth participated as first time applicants to the Creating Community Wellbeing Together [CCWT] program in January, 2005.
- ✓ Pallium Regional Weekend courses were held in Boundary Trails Health Centre (BTHC) and Altona and a Pallium Aboriginal Workshop was also organized in Portage la Prairie.
- ✓ Bereavement Support/Recovery Groups are occurring in seven communities in the Region.
- ✓ Official Opening of the Altona Health Resource Centre to house East Area Leader offices, and primary health services took place September 17, 2004.
- ✓ The name BabyFirst Early Start program was changed to Family First. Year-one evaluation data was released showing some positive outcomes with families involved with the program. Families First has opened new offices in Somerset and St. Jean and put a home visitor in each office.
- ✓ Healthy Baby Programs were held in Portage la Prairie (Portage Young Parents Resource Centre), Gladstone, Morden, Winkler, Altona, Morris, Lowe Farm, Carman and Swan Lake.
- ✓ In October, 2004, the government of Manitoba designated the *Conseil Communauté en Santé* (CCS) as the official representative of the francophone communities in the areas of health and social services. The *Table de concertation de la région du Centre*, responsible to the CCS for maintaining continual linkages with the RHA was established and participated in the development and validation of the French Language Services (FLS) Strategic Plan.

- ✓ The RHA in collaboration with the *Table de concertation,* received funding from the Primary Health Care Transition Fund (official language minority communities envelope) to develop a strategy to implement an ambulatory multidisciplinary team that can provide bilingual primary health care services to different localities across the Region.
- ✓ An integrated community committee is looking at possibilities to resolve elderly and disabled person transportation issues in the Morris area.
- ✓ Healthy Communities Conference 2004 hosted in Manitou: "Have You Ever Had a Bad Day" with keynote speaker Dick O'Brien. Over 160 participants learned about ways to develop resiliency and renewal to better manage stress during challenging times.
- ✓ With the purpose of sharing information, problem-solving and planning towards meeting the current and future health needs of citizens, stakeholder groups which include representation from key stakeholders and representatives from the Regional Health Authority – Central Manitoba (RHA Central) have been established throughout the Region.
- ✓ As there is a significant aboriginal population in the North Area, visits to all of the Chiefs and Councils of the First Nations communities in the North Area have been completed. The intent of the visits was to listen to their concerns about how services are rendered at the Portage District General Hospital (PDGH) and their suggestions re. health care. There have been good results from the meetings with Sandy Bay First Nation including:
    - o aboriginal awareness will become part of the North Area Regional General Orientation sessions
    - o an exchange program will be established between the PDGH and the Sandy Bay First Nation
    - o an interpreter's list will be developed and
    - o RHA Central will share its complaint policy with Sandy Bay First Nation. Sandy Bay First Nation will share their policy with PDGH once it is developed.
- ✓ MacGregor is promoting safety initiatives such as the MADD/MPIC video to warn of the perils of drinking and driving. The PARTY (Prevent Alcohol and Risk-related Trauma in Youth) program and Safe Kids Week were held in the spring of 2005. To promote healthy lifestyles, MacGregor & District Health Centre participated in the 28-day Becel challenge.
- ✓ To promote healthy living, an interdisciplinary team from Gladstone and Sandy Bay First Nation attended a diabetes workshop on risk factors and complications.
- ✓ Health Fairs for the communities at large - some were specific to children while others were geared towards those aged 55+.
- ✓ Educational events such as First Aid, CPR, Road/Vehicle and Bicycle Safety, Airbag Safety, Guard Against Frostbites, Over the Counter Cold/Flu Medications and their Interactions with Prescribed Medications, etc.
- ✓ Elderly Abuse Resource Guides.
- ✓ Many health facilities partnered with the local schools to provide healthy food choices with consultation and advice regarding menu items.
- ✓ Several communities are looking at enhanced housing and programming options for the elderly.
- ✓ An Aboriginal Cultural Awareness Workshop was held in the Swan Lake area.
- ✓ Notre Dame Services for Seniors in partnership with the Notre Dame Manor and *La Federation des Aînées Franco-Manitobain* received a grant to provide the Manor with education on nutrition.
- ✓ All of the Foundations that are health-related have made significant contributions to improving and enhancing the services provided by the RHA Central. For example:
    - o Foundation capital dollars allowed the Portage District General Hospital cataract surgery program to start on November 14, 2004. Manitoba Health provided operating funds for that program.
    - o On November 14, 2004, Minister Tim Sale attended a groundbreaking ceremony for the Portage District General Hospital CT scanner addition. A CT (computed tomography) scanner converts a standard x-ray into a three dimensional image and is used to diagnose brain and spinal cord injuries and diseases of the liver, lungs, kidneys and other abdominal organs. Other additional technologies such as PACS (Picture Archival and Communication System) and RIS (Radiology Information System)

were funded by the Foundation, as were the improvements to the waiting area. The new CT scanner will conduct more than 2,300 scans per year, resulting in reduced travel/enhanced care for clients in Central Region and take the pressure off current diagnostic waiting lists in urban centres.

- Renovations to the Portage District General Hospital Students' Residence were done to make the space more inviting and comfortable for the up and coming health professionals we hope to employ in the future.
- The Lions Prairie Manor Chapel was dedicated on April 29, 2005. The idea of a chapel resulted from many requests that were received over the years from residents, families and the clergy for a quiet place to hold worship services. This was a much-appreciated gift from the Lions Prairie Manor Foundation and its generous benefactors.
- The Community Services offices at MacGregor relocated adjacent to the MacGregor & District Health Centre in the former Grafton Place. For 2005-06 the MacGregor Health Foundation Inc. has purchased 24 chairs for the multi-purpose room and medical clinic plus a lawn mower/blower tractor. The Foundation has also donated towards mattresses, maintenance tools, commodes, workstations and a ceiling fan for healthy living and home care programs.
- Boundary Trails Health Centre (BTHC) Foundation hosted an Appreciation Dinner, April 23, in honor of Dr. Jacob, primary surgeon at Boundary Trails Health Centre. The Foundation raised over $34,000 to assist in the purchase of specialized equipment for BTHC.
- BTHC Winkler Auxiliary sponsored its 22nd Annual Miles for Smiles Walk. Over $27,000 was raised, which was used towards the purchase of a colonoscope and a titanium elastic nail system.
- Legends Car Club sponsored a car rally, raising $10,000: 50% dedicated to South Central Cancer Resource; the remaining 50% to CancerCare Foundation.
- The Carman Foundation approved $133,000 towards new computerized radiology services at the Carman Memorial Hospital.
- The community of Notre Dame de Lourdes raised over $1.5 million for the construction of a Wellness Centre.

- ✓ BTHC CancerCare Program hosted the annual CancerCare Manitoba Network Conference, April 29 – May 1, 2004 at the Heartland Inn in Winkler with record number of attendees.
- ✓ A Junior Volunteer program was started at BTHC.
- ✓ Pembina Manitou Health Centre hosted the regional Alzheimer's Conference, "I remember …..", on May 5, 2004.
- ✓ A Winkler Community Team comprised of representatives from the RCMP, Crown, Child and Family Services, Community Mental Health, BTHC ER Department, and Municipal Police were selected as one of 8 teams from across Canada to attend a three-day conference in Ottawa entitled "Making a Difference: Challenging the Legal Process to Effectively Prosecute Sex Offenders". The conference occurred in October, 2004. The purpose of the conference was to facilitate the team's capacity to respond to sexual assaults in a collaborative manner with law enforcement officials, forensic examiners, victim advocates and prosecutors.
- ✓ The inaugural meeting of the Winkler Senior's Planning Council was held on November 17, 2004. This Council was created to facilitate intersectorial partnerships that will enhance coordination of services, address service gaps and expand service options fundamental to creating comprehensive, community-based programs for seniors. The ultimate

vision of the Council is to maximize the independence of seniors, promote ageing in place, and optimize their quality of life.

- ✓ BTHC Palliative Care and Community CancerCare Program implemented a Dying at Home program. The Boundary Trails Health Centre Foundation contributed of $8,079.24 to purchase the equipment needed for palliative care home patients.
- ✓ The BTHC Winkler Auxiliary hosted the "Unveiling of the Heritage Quilt": a stunning work of art crafted from quilt blocks created in 1932 by Mrs. Helen Wiebe (the founding member of the Winkler Auxiliary and wife of the late Dr. C.W. Wiebe). The BTHC Winkler Auxiliary has dedicated this quilt to BTHC.
- ✓ Living Works facilitated an Applied Suicide Intervention Skills Training (ASIST) Workshop in Pilot Mound. This workshop was designed to provide practical help for individuals seeking to prevent the immediate risk of suicide. The workshop was successfully attended by 40 registrants, including representatives form the health, education and justice sectors. A similar workshop was also held in Portage la Prairie.
- ✓ The Rock Lake Communities developed a Community Crisis Response Team to be available in the event of a critical incident or a traumatic event. This team is made up of community residents who are available 24-hours/seven days a week to respond where needed. The mission of this team is to provide immediate post intervention to individuals, families or anyone in the community who has been affected by a critical incident, a traumatic event or crisis.
- ✓ Prairie View Lodge (PVL) celebrated it's 40th Anniversary, June 23, 2005. Representatives of the United Church of Canada, residents of PVL and many community members attended.
- ✓ Seniors' program worked in partnership with communities to develop an Elder Abuse Resource Guide and Flowchart where caregivers and the community will be educated, able to identify and be able to report abuse.
- ✓ Thanks to partnerships between community organizations and health care workers, community-wide health assessments were carried out in Notre Dame and area, St. Claude and area and Swan Lake and area. The results of the assessments provided the community with the information required to now develop a plan capable of helping their community truly become AS HEALTHY AS CAN BE. We are already seeing significant projects emerging as a result of these assessments. Lorne Foundation and St. Claude Health Foundation provided funds for the assessments.

Goal 4: A structure that will be ready to respond to future fiscal and human resource challenges and is essentially cost-neutral.

- ✓ In 2003, a Practical Nursing Program for 26 students commenced at the former Bethel Hospital. This program was achieved through the committed efforts of the following stakeholders: Assiniboine Community College, Regional Health Authority – Central Manitoba Inc., Manitoba Advanced Education and Training, Salem Home Inc., Tabor Home Inc., the City of Winkler and Garden Valley Collegiate Institute. Graduation services were held on June 4, 2004, at the Grace Mennonite Church in Winkler. All 24 graduates were in attendance. Seventeen graduated with distinction. The students wrote their national examinations on May 18, 2004 and were all successful in obtaining licensure. All of the Licensed Practical Nurses have secured employment: many in RHA Central.
- ✓ Emerson acute care services remain in curtailment due to inability to recruit and maintain RN services.
- ✓ Lack of trained staff caused a reduction in lab services at Emerson Health Centre and community leaders met with local physicians to agree on level of services and long-term impact.
- ✓ Effective October 1, 2004, ER and acute care services at Pembina Manitou Health Centre (PMHC) were curtailed secondary to RN shortages. RHA representatives and community stakeholders have worked collaboratively over the past several months to ensure immediate health care needs of the community are met and to plan for appropriate and sustainable services for the future.

- ✓ Community Services were relocated to office space within existing facilities in Altona, Emerson and Morris to promote continuity of care and promote fiscal responsibility.
- ✓ A pilot project was approved to upgrade Licensed Practical Nurses to diploma level Registered Nurses utilizing video streaming technology. This program allows nurses to remain in their home communities while receiving their training. If successful, it is hoped that this program can be continued and expanded and could go a long way in meeting our future nursing requirements. It is also possible that this type of technology could be used to train other health care professionals, e.g. medical technologists.
- ✓ A regional Staff Satisfaction Survey was conducted in 2004/05 with a 43% response rate from staff. The results showed that in excess of 70% of staff indicated that they were "Satisfied" or "Very Satisfied" with their jobs.
- ✓ Two LPN classes graduated in our Region in 2004/05. One in Winkler in June, 2004 and the second in Portage in January, 2005.
- ✓ The RHA successfully partnered with the City of Winkler to establish housing accommodations for health care students completing Practical Training at local health care facilities. Students were able to access housing commencing September, 2004.

- ✓ Educational opportunities were provided to the staff in leadership role. Examples include:
  - Providing literature on Managing Transitions
  - Facilitator Skills/Engaging the Community
  - Attendance Management Workshops
  - Presentations on Nursing Leadership
  - Workshop for the nurses on Teamwork Magic.
- ✓ Many educational opportunities were provided to our staff on the topic of service delivery. The focus was that staff are the RHA and the way that they choose to carry out everyday activities has a significant impact on our clients. Examples of the educational session provided are as follows:
  - The Business of Customer Service in Health Care
  - Customer-Focused Health Care Environment
  - Balancing Work and Life Roles
  - Presentation on Workplace Wellness
  - Boyne Lodge has a staff initiated Staff Morale program
  - Trauma Nursing Care Course
  - Respectful Workplace seminars.
- ✓ Utilization reviews were conducted across the Region in areas of Emergency Room utilization where more than 75% of ER visits were in the category of non-urgent care; surgical care; and medical care by five most common diagnoses.

Goal 5: More rapid decision-making at the service delivery level based on corporate/regional policies and standards of practice

- ✓ Improved utilization of existing information technology through access and training for facility accounting and dietary staff to input data directly into computer programs (i.e. Momentum/Great Plains/RMS).
- ✓ The finance department decentralized out to the Areas in 2004 allowing for better communication, education and reporting to the managers.

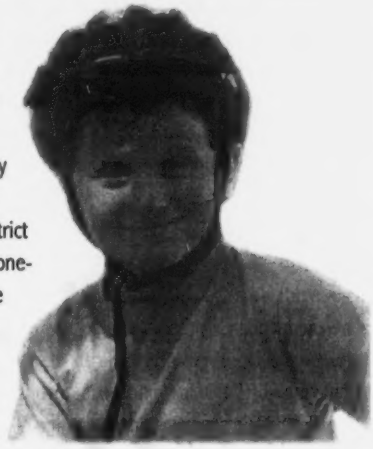
- ✓ Managerial Reporting was developed to give the manager more timely reports that will allow them to make informed decisions and to give the manager more timely reports that will allow them to make informed decisions. Targeted savings were monitored throughout the year by Financial Analysts in each of the Areas.
- ✓ Information technology support, maintenance project processes were developed and implemented and an automated network monitoring tool was put in place.
- ✓ ICD10 increased reporting capabilities from a centralized database now assists with enhanced evidenced-based decision-making, utilization and planning efforts for acute care-based programs and participation in and compliance with national and international standards.
- ✓ Renovation projects were completed throughout the Region to improve functionality safety and security.
- ✓ Regional Air-Quality Testing schedule was developed by Altona and Morris Environmental Service Managers.
- ✓ A Home Care Office was relocated in the Notre Dame area in order to provide bilingual services within the designated French Language Services area.
- ✓ The regional Nutrition Manual was completed and distributed throughout the Region. It is available in print form, on CD and on the Intranet.
- ✓ Aggression Management Workshops for staff were provided on a regular basis throughout the area.
- ✓ Staff were provided with some basic training for computer and e-mail use.

Goal 6: Best practice and high standards of professionalism

- ✓ The completed Regional Staff Workplace Survey results were shared throughout the organization.
- ✓ Managing and Reporting of Occurrences was formalized regionally and inservices held locally with staff.
- ✓ Acute Coronary Syndrome Care-mapping was implemented after staff training was completed.
- ✓ Restraint policy was revised, education provided and implemented in long term and acute care.
- ✓ Protection for Persons in Care inservices held for staff to promote awareness and compliance with legislation.
- ✓ Patient Safety Consultations were organized with community participants from the East Area.
- ✓ Successful implementation of ICD10 with subsequent internal standard development and ongoing education. Successful in meeting Manitoba Health's abstract deadline submission date of May 16, 2005, with all facilities having completed their coding and abstracting for the 2004-05 fiscal year.
- ✓ Successful regional implementation and operationalisation of the Retention and Destruction of Personal Health Information Policy and the Completion of Health Records Policy.
- ✓ The Children's Therapy Initiative proposal was approved with some new funding being provided by the Province of Manitoba to begin implementation of the plan. The mandate of the proposal was to develop a plan for therapy service for our Region which was to be family and child-centered, accessible, equitable, timely, comprehensive and coordinated, adequately resourced, able to be evaluated and supported by a central database. The plan is to achieve six provincial outcomes; regional partnerships, family-centered access to information and service, common intake, continuum of services, transition planning and evaluation.

- ✓ Members of the RHA Central Board visited schools to talk with youth about issues related to health. The Child and Adolescent Team reviewed the notes from the visits and have tried to highlight some common themes and messages. The team will use the information gathered from these visits to help develop their strategic plan.

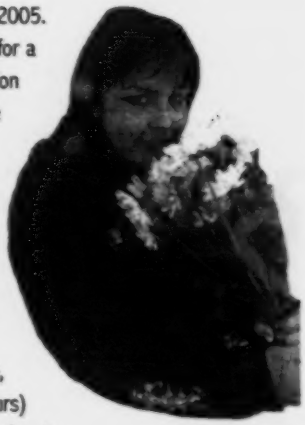
- ✓ A table top display to inform staff and the public about our regional women's health strategic directions, along with supportive key messages was developed and is available for communities/groups to use when there are events in the Areas such as screening/health fairs etc.
- ✓ Revisions and development of regional women's health policies, striving for 'best practice' and consistency across the Region has occurred with policy examples such as; 'CODE PINK '(Infant abduction), and Antibiotic Resistant Organism (ARO) guidelines.
- ✓ A breastfeeding performance deliverable document was submitted to Manitoba Health that focused on the promotion of breastfeeding through education and support of 'best practice' guidelines for health care providers.
- ✓ In partnership with Douglas College, three staff were trained as trainers of the 'Breastfeeding Counselor certificate program to be offered within the Region in 2005.
- ✓ 'Baby Friendly' resources produced by the province (crib cards, measuring tapes and fridge magnets) to replace those previously produced by formula companies, were distributed throughout the Region to promote breastfeeding initiation and duration.
- ✓ The impact of Manitoba Health's revised immunization schedule resulted in the doubling of the Region's childhood immunization program.
- ✓ An Immunization performance deliverable document, focusing on MIMS access and timely inputting throughout the Region was submitted to Manitoba Health.
- ✓ A Public Health Nurse Orientation framework and checklist was developed with plans to build self-learning modules for each practice area.
- ✓ Draft Priority Guidelines, adapted from the work of the provincial network was developed to guide practice decisions.
- ✓ The Regional Pharmacy and Therapeutics Committee has instituted a regular review of the Institute of Safe Medication Practices (ISMP) newsletters as part of it regular meetings.
- ✓ The harmonisation of a Regional Formulary for medications has been completed and a regularly updated electronic version has been created and posted on the Intranet for staff to access.
- ✓ A successful Asthma Education Program was run by the pharmacy department at the Portage District General Hospital during the 2004/05 year. This program was a valuable resource helping patients with asthma maintain proper control of the symptoms and avoid hospital admissions.
- ✓ Regional Director of Pharmacy made a presentation at the Provincial Pharmacy Conference on cardiovascular risk in people with diabetes.
- ✓ The National Film Board of Canada did a photo shoot in the Portage District General Hospital Intensive Care Unit on November 8, 2004. The film was a one-hour presentation, focusing on the subject of aboriginals and diabetes. The film will be available on a national basis for distribution in the area of health care.



- ✓ CancerCare Manitoba (CCMB) conducted it's annual site visit of the BTHC Community Cancer Program (CCP). The BTHC CCP was commended for its excellence in patient care and was heralded as one of the most progressive CCPs in Manitoba. Highlighting the visit was a presentation to the BTHC CCP of $4,565 by the RCMP Run for Cancer organization.
- ✓ Representatives from Norway House Health Services Inc. have made several visits to BTHC to review our models of health services delivery and physical plant operations. They have commended BTHC for the high levels of clinical integration and expertise that the facility has attained and hope to achieve similar success in their venture. We will be continuing a collaborative partnership with Norway House Health Services Inc. as they pursue their vision.

- ✓ Manitoba Health approved expansion of the BTHC Orthopedic Program to include 50 additional total hip and 55 total knee procedures, bringing joint replacement surgical care closer to home for Central's citizens. Dr. Jeff Engle accepted the full-time orthopedic surgeon role at BTHC, a critical step towards ensuring implementation of this fabulous opportunity.
- ✓ The Region submitted a status report to the Canadian Council of Health Services Accreditation (CCHSA) on the high priority recommendations from the 2003 health system survey. In July, 2004, CCHSA confirmed the accreditation of the organization.
- ✓ An environmental risk assessment was done across the Region with the utilization of the modules from the Health Insurance Reciprocal of Canada (HIROC). Actions plans were developed to improve quality of care and mitigate risks.
- ✓ The Region adhered to the remaining recommendations of the Thomas Commission Report by revising key policies. An updated status report was sent to Manitoba Health in July, 2004. The Regional Occurrence Reporting policy was updated with comprehensive education to employees, physicians, and managers across the Region. The Region also demonstrated compliance by establishing a written Corporate Risk Management framework. The risks have been captured into four key categories relating to system competency, organizational responsiveness, worklife, and client /community dimensions.
- ✓ Pain Management practice guidelines were developed and rolled out to the Region.
- ✓ The RHA established regional standardized care protocols for Acute Coronary Syndrome; Bronchiolitis; Triage Assessment; Cerebral Vascular Accident; Wound Care and Myocardial Infarction.
- ✓ Standardized regional policies in acute care such as tissue count, consent and site-verification in surgery, notice of death, alternate levels of care and nurse-managed care were developed.
- ✓ Ten standardized patient education handouts were developed.

A GLANCE AHEAD (APRIL – OCTOBER, 2005)



- ✓ An Aboriginal Recruitment and Retention Coordinator commenced employment in August, 2005. Funding has been approved by Aboriginal and Northern Affairs and Advanced Education for a one-year term position. This individual will assist in developing a recruitment and retention plan aimed at involving more aboriginals in our workforce and ultimately helping to provide more culturally-sensitive care to our aboriginal population.
- ✓ In partnership with the Winnipeg Regional Health Authority (WRHA), a regional training opportunity on Best Practice Guidelines for Breastfeeding will be available fall 2005, for all health care providers working with breastfeeding families. These guidelines incorporate the use of the LATCH-R tool, a 'made in Manitoba' resource that is a research-based breastfeeding assessment tool. Use of this tool throughout the Region has the potential to ensure that both early and later breastfeeding problems will be managed in a timely, accurate and consistent manner. In partnership with Douglas College, the breastfeeding counselor certificate program (39 classroom hours and 38 practical hours) will be offered. Training and Implementation of the newly revised Postpartum and infant referral forms which are used across the province by delivering facilities and Midwives, will take place October 1, 2005.
- ✓ Pharmacy services in Central Region coordinated a provincial conference for pharmacy managers in September, 2005, on the "Intersection of Patient Safety and Technology". The meeting will bring together speakers from Canada and the United States for a critical review of the technological innovations that may make medication delivery in hospitals safer.
- ✓ Pharmacy services will participate in the "Safer Health Care Now" with a program to address medication reconciliation during patient transfer. This program will help to ensure seamless an accurate medication orders when patients move in the community – hospital continuum.
- ✓ Representative hospitals from each of the four RHA areas will complete the Institute for Safe Medication Practices (ISMP) self-assessment survey during the fall of 2005. This survey will allow for an examination of safety practices in the RHA and comparison with other hospitals from around the country.
- ✓ Pharmacy services are actively involved in recruitment for hospital pharmacists to fill several current vacancies. The service is actively involved with Faculty of Pharmacy providing summer training and hospital training rotations and the Region's hospitals. Pharmacy services will present to 4th-year pharmacy students as part of a program with the Office of Rural and Northern Health.
- ✓ Several of the pharmacies (retail and hospital) in Central Region will participate in the CRIMP (Cardiovascular Risk Intervention by Manitoba Pharmacists) program. This program will provide resources to pharmacists to help them identify patients at high-risk for cardiovascular events. Pharmacists will work with patients and physicians to optimise pharmacotherapy to prevent cardiovascular events.
- ✓ An audit will be conducted on the proper use of hypertonic normal saline in the first six months of 2005/2006. This audit will help to ensure the use of the regional guideline on the treatment of hyponatremia is followed when hypertonic saline is used.
- ✓ Policy on high-risk medications and sound-alike medications – are under development by the Regional P&T committee.
- ✓ The Regional Pharmacy & Therapeutics (P&T) committee has recommended the delisting of oral meperidine in response to the recommendations of ISMP. This narcotic pain reliever has been associated with significant side effects when used in patients with insufficient renal function. Safer alternatives exist to this product.

- ✓ A physician was recruited to work in Rosenort, and we continue to evaluate the needs of Montcalm.
- ✓ In partnership with community representatives of St. Jean Baptiste, a facility was constructed to provide primary health services to the area residents. Letellier Home Care, St. Jean Public Health, Families First Home Visitor and Services to Seniors were moved to the new Montcalm Health Centre in April/May and the Grand Opening was held on June 24, 2005.
- ✓ Services to Seniors programs completed Memorandum Of Understandings to provide accountability for program funding and to strengthen integration of services along the continuum of care.
- ✓ The Region plans for Accreditation Standards Visit in 2006.
- ✓ Long Term Care Standards completed in preparation for fall 2005 site review.
- ✓ Adverse weather conditions impacted the East Area facilities and staff, personally and professionally. Although it was not utilized this year, it was reassuring to know the flood evacuation plan had just recently been reviewed and revised.
- ✓ A fee-for-service 'Travel Health Immunization program was developed with anticipated start date October, 2005.
- ✓ The Portage Seniors' Program Planning Table which encompasses the whole spectrum of seniors in Portage la Prairie is looking at gaps in services, how we can improve our services and move forward in an integrated manner. Plans are in place to accomplish this. Leadership tables from the Lions Prairie Manor and Douglas Campbell Lodge have combined to work together as one unit, to accomplish common practice and better client outcomes.
- ✓ We are also contributing to the provincial ventures arising from the First Ministers' Plan to strengthen Health Care through participation in the Provincial Total Joint Replacement Wait Time Reduction Working Group. A proposal for an additional expansion of the Boundary Trails Health Centre Total Joint Replacement program has been submitted accordingly.
- ✓ MacGregor is partnering with a faculty member with Brandon University and the Rural Development Institute to conduct a community health assessment.
- ✓ In 2005/06, Seniors Program will be working in partnership with communities to explore housing options for seniors with appropriate supports relevant to seniors' needs.
- ✓ Approval for construction of a new ambulance garage in Carman was received.
- ✓ As we journey into the next exciting year, we will be moving forward with initiatives that address the determinants of health as we promote healthy lifestyles at work, school and home on such ventures as:
    - o P.A.R.T.Y. Program (Prevent Alcohol and Risk-related Trauma in Youth)
    - o Workplace Wellness
    - o Working with local school boards to implement Healthy Food Options
    - o Taking the One-Tonne Challenge
    - o Implementing healthy living initiatives in the communities of Morden/Winkler and Pilot Mound as part of our Creating Community Wellbeing Together program
    - o Strengthening our relations across all agencies and sectors within our communities as well all play a critical role in the health of people in Central Region.

REPORT ON PERFORMANCE

RHA CENTRAL 2004-05 ANNUAL REPORT

In 2004, RHA Central published its second comprehensive Community Health Assessment document (available on our web site at http://www.rha-central.mb.ca). This document was a result of almost two years of data collection and analysis. Because of this extensive collection of data, in our 2003-04 Annual Report, we were able to provide our public with almost 50 pages of data and information pertaining to our Board ENDs and performance measures. Some of our Board END performance measures rely on survey data (such as the Canadian Community Health Survey) which is conducted every two years, as well as special reports and analysis prepared by the Manitoba Centre for Health Policy, CancerCare Manitoba and various divisions within Manitoba Health. Instead of repeating the data already presented in our previous annual report (available on our web site at http://www.rha-central.mb.ca/en/pdfs/FINALreport.pdf), in this report we present some new data and where possible we show you how our performance measures compare to other regions, the province and Canada.

BOARD END **INDIVIDUALS** in Central Region are AS HEALTHY AS THEY CAN BE.

OUTCOMES

- Individuals are aware of and demonstrate healthy lifestyle behaviours
- Individuals experience physical wellbeing
  - Individuals are free from preventable illness, death and injury
  - Individuals have healthy weights
- Individuals experience emotional, spiritual & social wellbeing
  - Individuals have healthy relationships
  - Individuals experience healthy family environments
  - Individuals perceive a supportive network within their community
- Individuals have a safe environment
- Individuals have safe physical environments where they work and live
  - Individuals have safe water supplies
  - Individuals breathe healthy air
- Individuals in need of health care experience a timely return to their optimal health
- Individuals receive appropriate care
- Individuals are treated with dignity.

Performance Measures reported in 2003-04

In our 2003-04 Annual Report we presented information about the following performance measures related to individuals:

- Premature mortality
- Potential Years of Life Lost
- Morbidity rate
  - Cancer
  - Injuries
  - Hospitalization rates
  - Chronic diseases
- Self-rated health
- Weight
- Smoking
- Physical activity
- High blood pressure
- Life stress
- Housing.

2004-05 Performance Measures

- Nutrition
- Ambulatory care sensitive conditions
- Activity limitation
- Water quality
- Overall mortality
- Mortality by selected diseases
  - Circulatory diseases
  - Respiratory diseases
  - Cancer
  - Pneumonia and influenza
- Unintentional injury mortality
- Suicide.

Performance Measure NUTRITION

Significance of this Measure

There is currently a great deal of concern and media attention regarding the issue of trans fat in our diet. In August, 2005, the interim report of the Trans Fat Task Force was released and according to Minister of Health Ujjal Dosanjh, "Canadians' consumption of trans fats is one of the highest in the world."

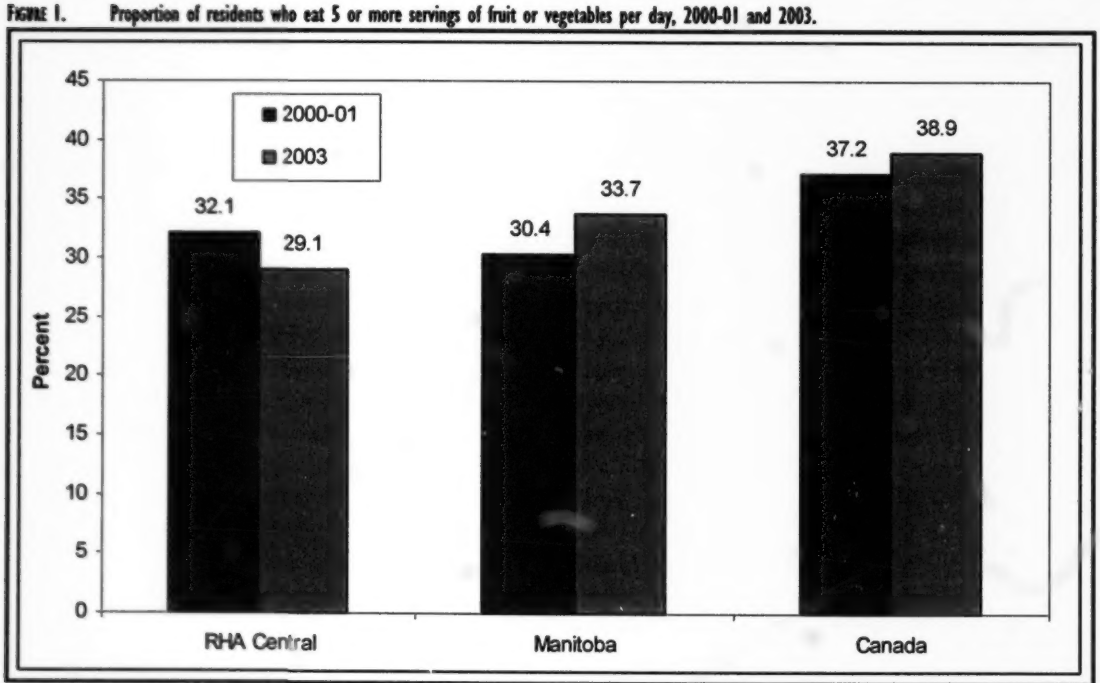
Canada's Guidelines to Healthy Eating advises Canadians to choose lower fat dairy products, leaner meats and foods prepared with little or no fat. We can significantly reduce our intake of saturated and trans fats by avoiding commercially fried foods and high fat bakery products. Eating more vegetables and fruit, whole grain breads and cereals, peas, beans, lentils and nuts, will also result in lower intakes of both saturated and trans fats.

While we do not have Region-specific data on consumption of trans fat, we do have information about healthy choices such as fruit and vegetable consumption.

Performance Highlights

In 2003, 29.1 per cent of Central Region residents age 12 and older reported consuming fruits and vegetables five or more times per day. This is lower than the provincial rate of 33.7 per cent and the Canadian rate of 38.9 per cent. In addition, it also represents a decrease from the first Canadian Community Health Survey in 2000-01 (see FIGURE 1).

FIGURE 1. Proportion of residents who eat 5 or more servings of fruit or vegetables per day, 2000-01 and 2003.



Source:Canadian Community Health Survey, Cycle 1.1 (2000-01) and Cycle 2.1 (2003).

Performance Measure

AMBULATORY CARE SENSITIVE CONDITIONS

Significance of this Measure

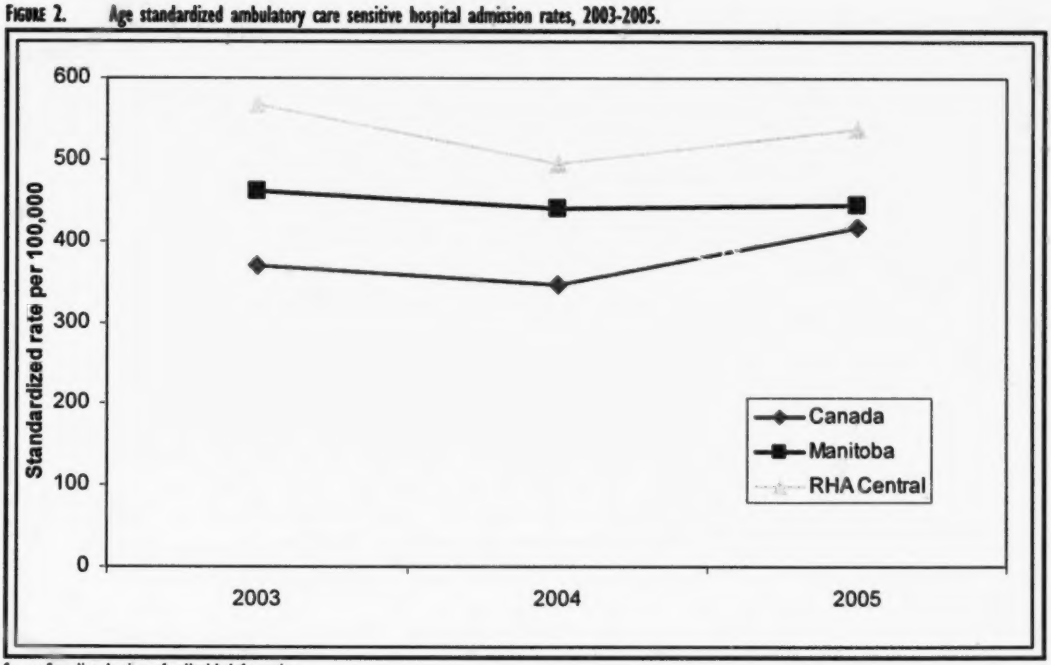
Ambulatory care sensitive conditions are those conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital. For example, diabetes and asthma are considered "ambulatory care sensitive conditions"— chronic conditions that may lead to the use of emergency health care services or hospitalization but, often, can be managed by patients who are active in their own care, with help from physicians or other community-based health care providers.

While not all admissions for ambulatory care sensitive conditions are avoidable, in many cases, appropriate prior ambulatory care can prevent the onset of these types of illness or conditions, control an acute episodic illness or condition, or manage a chronic disease or condition. The "right" level of utilization is not known although a disproportionately high rate may reflect problems in obtaining access to primary care.

Performance Highlights

Comparative data for our Region, Manitoba and Canada is available for the years 2003-2005. As FIGURE 2 shows, our ambulatory care sensitive condition hospitalization rates have been significantly higher than both the province and Canada. We will need to continue to review data over the next few years to see if our rates are continuing to remain high.

FIGURE 2. Age standardized ambulatory care sensitive hospital admission rates, 2003-2005.



Source:Canadian Institute for Health Information.

Performance Measure ACTIVITY LIMITATION

Significance of this Measure

People with activity limitations can have their quality of life significantly impacted. For example, data from the National Population Health Survey has shown that Canadians with activity limitations are more likely to have lower incomes than those people without limitations. In this measure, activity limitation refers to those people aged 12 and over who report being limited in selected activities (home, school, work and other) because of a physical condition, mental condition, or health problem which has lasted or is expected to last six months or longer.

Performance Highlights

In our Region, over one in five residents (21.7%) over age 12 indicated that they had an activity limitation when interviewed for the 2003 Canadian Community Health Survey. This is an increase from our rate in the first survey cycle of 18.5 per cent but is lower than the provincial rate of 24.2 per cent.

Performance Measure WATER QUALITY

Significance of this Measure

Clean water is essential to life. Our health and wellbeing depend on it. Due to significant flooding in the summer of 2005, the province tested water from private wells free of charge. As a result of this initiation, 4,500 samples were received and tested.

Performance Highlights

Although Region-specific data is not available for ground water wells, we can learn from the provincial level data. Of the 4,500 samples tested, 42 per cent tested positive for total coliform bacteria, and 2.7 per cent tested positive for E. Coli. Month-by-month analysis of the samples indicated that the rates of contaminants decreased between early July and the end of August. This data is very important for two reasons as it illustrates that:

- Aquifers are vulnerable to contamination during periods of prolonged and excessive rain
- Aquifers can recover if the contaminant pathways (the source of the bacteria) are suitably addressed.

For further information about drinking water and care of private wells, please see www.manitoba.ca/drinkingwater.

Performance Measure OVERALL MORTALITY

Significance of this Measure

Overall mortality includes deaths from all causes. This rate is useful in that it indicates the overall health of the population and is similar to what is measured by life expectancy.

Performance Highlights

According to Statistics Canada, in 2001, Central Region standardized mortality rate was 599.4 deaths per 100,000 residents. This was lower than both the provincial (649.4 per 100,000) and Canadian (605.3 per 100,000) rates in the same time period. Within our Region, standardized mortality rates are much higher among men at 730 deaths per 100,000 than among women (491.2 deaths per 100,000).

Performance Measure MORTALITY BY SELECTED DISEASES

- Circulatory diseases (this includes – but is not limited to - cerebrovascular disease, such as stroke, as well as ischemic heart disease)
- Respiratory diseases (this includes – but is not limited to - pneumonia and influenza, bronchitis, emphysema and asthma)
- Cancer
- Pneumonia and influenza.

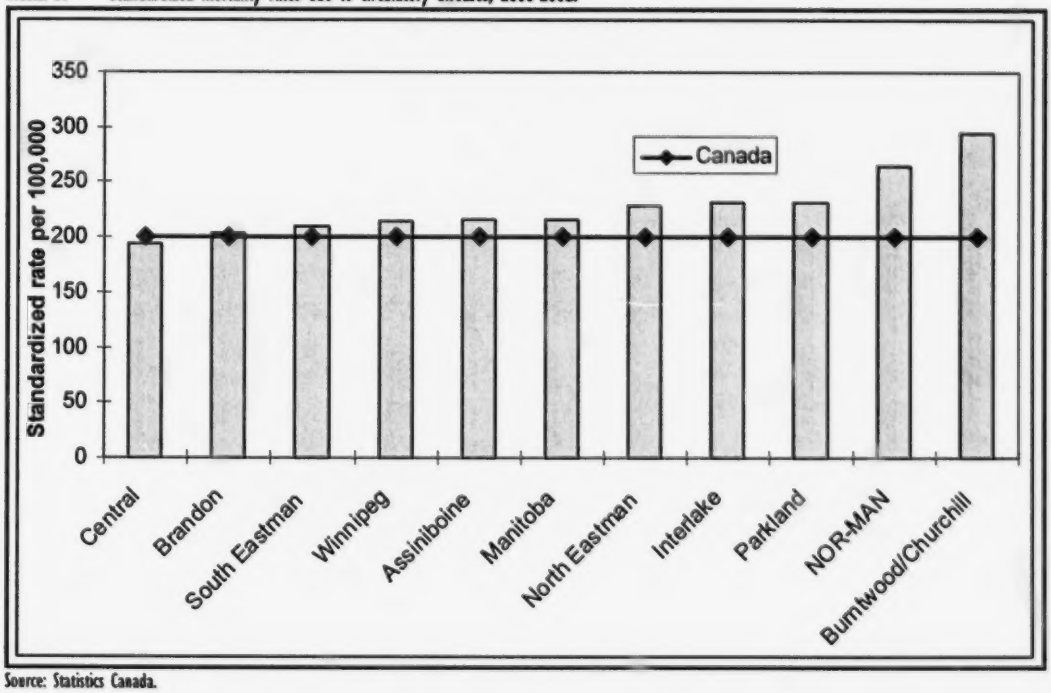
Significance of this Measure

These cause specific mortality rates help us to measures long-term success in reducing deaths due to certain diseases compared with other regions, provinces, and countries. Lower death rates indicate success in disease prevention, detection, and treatment.

Performance Highlights

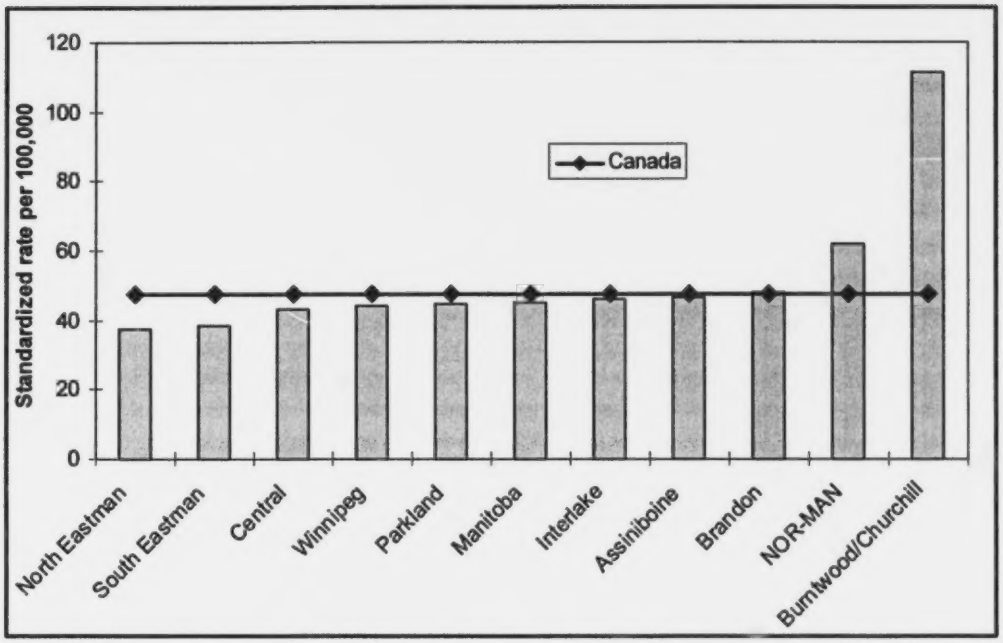
Central Region residents are a very healthy group of people. When we look at our rate of deaths due to most of the selected causes (see FIGURES 3 to 7), we can see that we are among the lowest in Manitoba and are lower than the Canadian mortality rates as well. The exception to this is deaths due to pneumonia and influenza (see FIGURE 7) where our standardized regional death rate of 15.6 per 100,000 is higher than both the provincial rate of 11.7 per 100,000 and the Canadian rate of 12.5 per 100,000. Although deaths due to pneumonia are relatively rare compared to the other causes of death we present in this report, they are important because in many cases they can be prevented through appropriate immunization of those most at risk (such as the elderly and people with certain chronic diseases).

FIGURE 3. Standardized mortality rates due to circulatory diseases, 2000-2002.



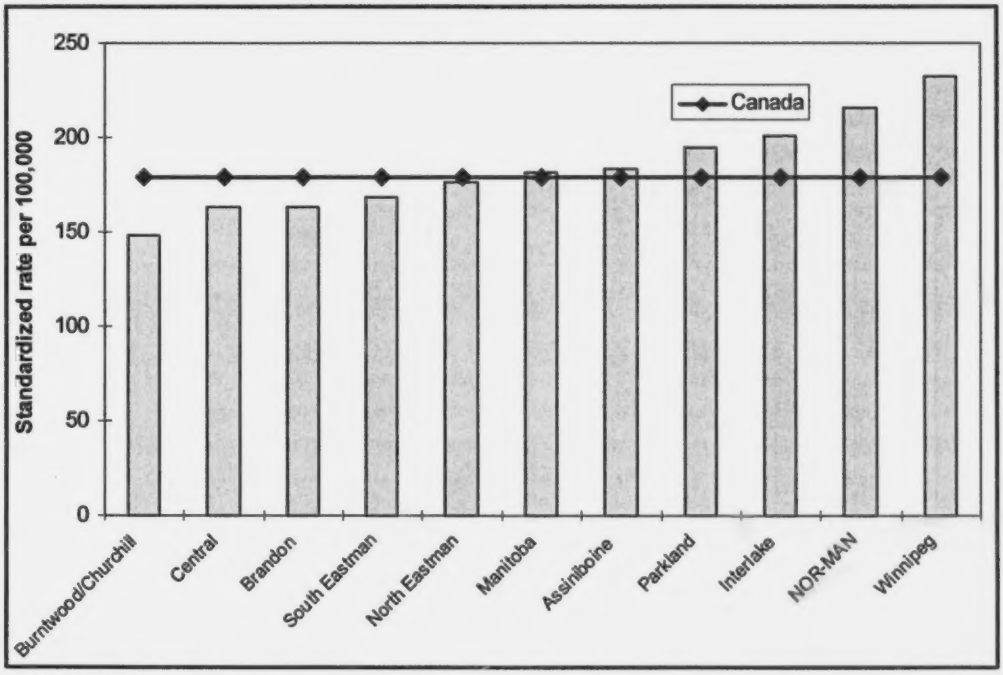
Source: Statistics Canada.

FIGURE 4. Standardized respiratory disease mortality rates, 2000-2002.



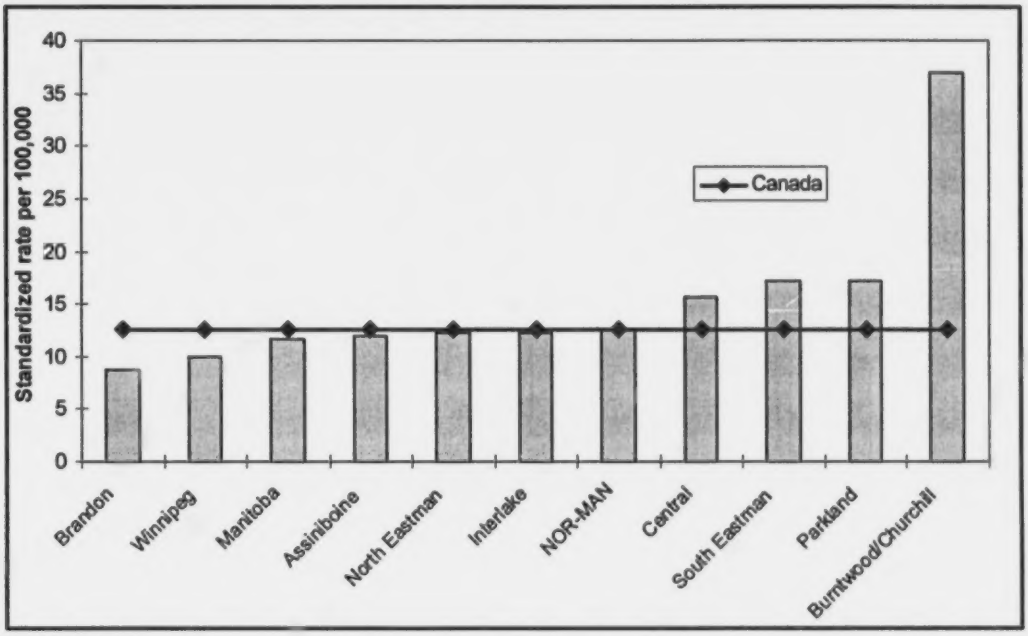
Source:Statistics Canada.

FIGURE 5. Standardized cancer mortality rates, 2000-2002.



Source:Statistics Canada.

FIGURE 6. Standardized pneumonia and influenza mortality rates, 2000-2002.



Source:Statistics Canada.

Performance Measure UNINTENTIONAL INJURY MORTALITY

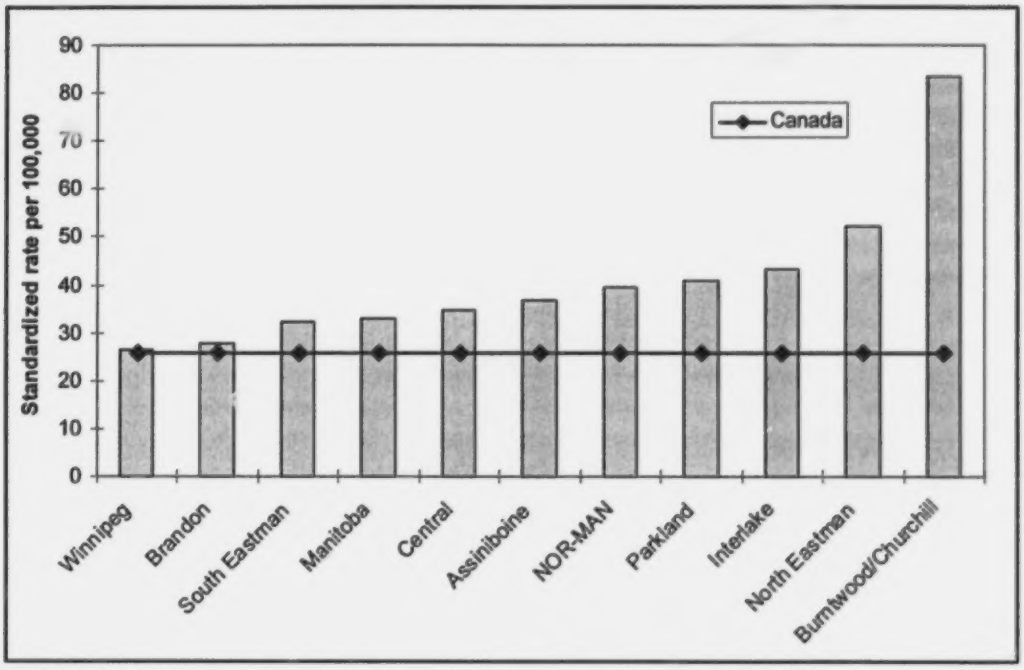
Significance of this Measure

Unintentional injury mortality rates can be used to measure long-term success in reducing deaths due to unintentional injuries, compared with other regions, provinces, and countries. This information helps us to evaluate the adequacy and effectiveness of injury prevention efforts, including public education, community and road design, prevention, emergency care, and treatment resources.

Performance Highlights

As we can see from FIGURE 7, deaths due to unintentional injuries is an issue that we must address in Manitoba. Not only is the provincial rate (of 33 deaths per 100,000) higher than the Canadian death rate (of 25.6 deaths per 100,000), death rates are higher than Canada in every region of our province. Within our Region, the standardized death rate is slightly higher than Manitoba at 34.8 deaths per 100,000. Central Region rates are much higher among men at 48.8 deaths per 100,000 than women at 21.4 deaths per 100,000.

FIGURE 7. Standardized unintentional injury mortality rates, 2000-2002.



Source:Statistics Canada.

Performance Measure SUICIDE

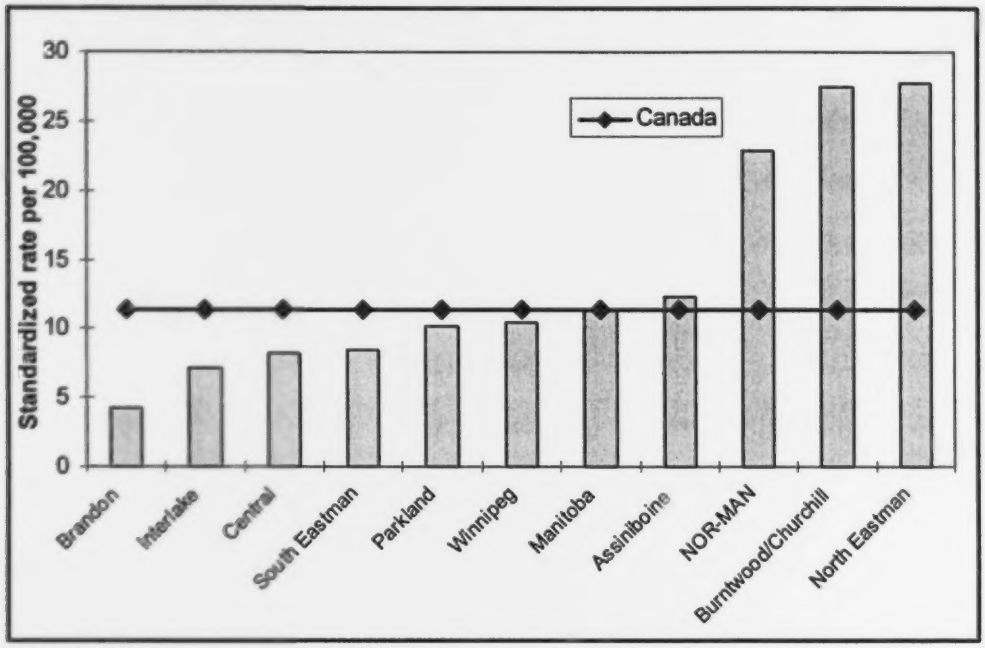
Significance of this Measure

Suicide rates are a major social and public health concern. We are particularly concerned about the suicide rates among young men and Aboriginal residents, as well as suicide attempts among young women.

Performance Highlights

Between 2000 and 2002, Central Region had one of the lowest standardized rates of suicide in Manitoba at 8.2 deaths per 100,000 (see FIGURE 8). Central Region must continue to focus on suicide prevention as well as developing ongoing strategies for helping people who have attempted suicide in the past.

FIGURE 8. Suicide rates, 2000-2002.

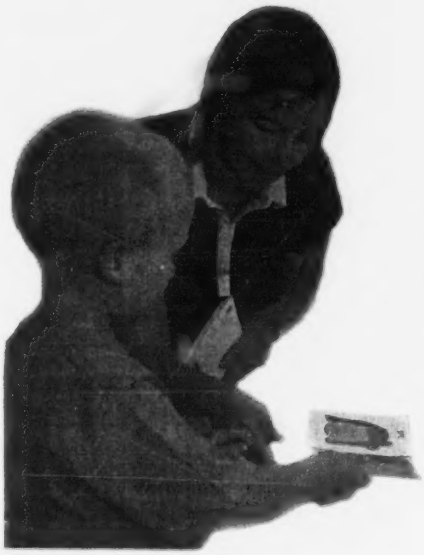


Source:Statistics Canada.

BOARD END CHILDREN are AS HEALTHY AS THEY CAN BE.

OUTCOMES

- Children have healthy growth and development
  - Children do not die in infancy
  - Children remain free from preventable death or injury
  - Children are protected from communicable diseases
  - Children are physically active
  - Children practice healthy eating
- Children are born without and remain free from the harmful effects of tobacco, alcohol, drugs and solvents
- Children have responsible and effective guardianship
- Children have high levels of self-esteem
- Children make age-appropriate and culturally appropriate lifestyle choices
- Children have access to the highest educational attainment
- Children feel safe in their environment.



Performance Measures reported in 2003-04

In our 2003-04 Annual Report we presented information about the following performance measures related to children:

- Infant mortality
- Teen pregnancy
- Sexually Transmitted Diseases
- Weight
- Alcohol consumption
- Smoking
- Immunization.

2004-05 Performance Measures

- Breastfeeding initiation
- Low birthweight
- Physical activity
- Nutrition
- Exposure to second hand smoke
- Readiness to learn.

Performance Measure BREASTFEEDING INITIATION

Significance of this Measure

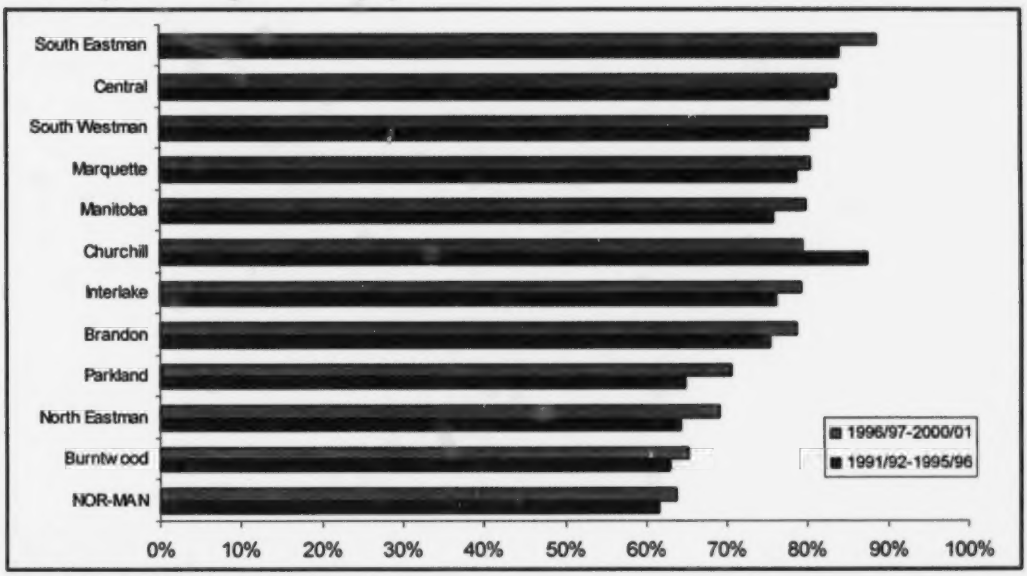
Breastfeeding is identified as the best way to provide optimal nutritional, immunological and emotional nurturing for the growth and development of infants[ii]. The Joint Statement on Nutrition for Healthy Term Infants from Canadian Pediatric Society, Dietitians of Canada and Health Canada[iii] recommends exclusive breastfeeding for at least the first four months of life

and to continue breastfeeding for up to two years or more. Breastfeeding ensures a safe, secure and self-reliant food source that is nutritionally efficient and complete and ecologically sound, and it can benefit the mother physically, psychologically and economically[iv]. Active public health, hospital, community and workplace support will increase initiation and duration of breastfeeding.

Performance Highlights

Hospitalization data can give us some information about whether the mother started breastfeeding in the hospital. According to this data (see FIGURE 9), over 80 per cent of Central Region mothers initiated breastfeeding in both time periods examined.

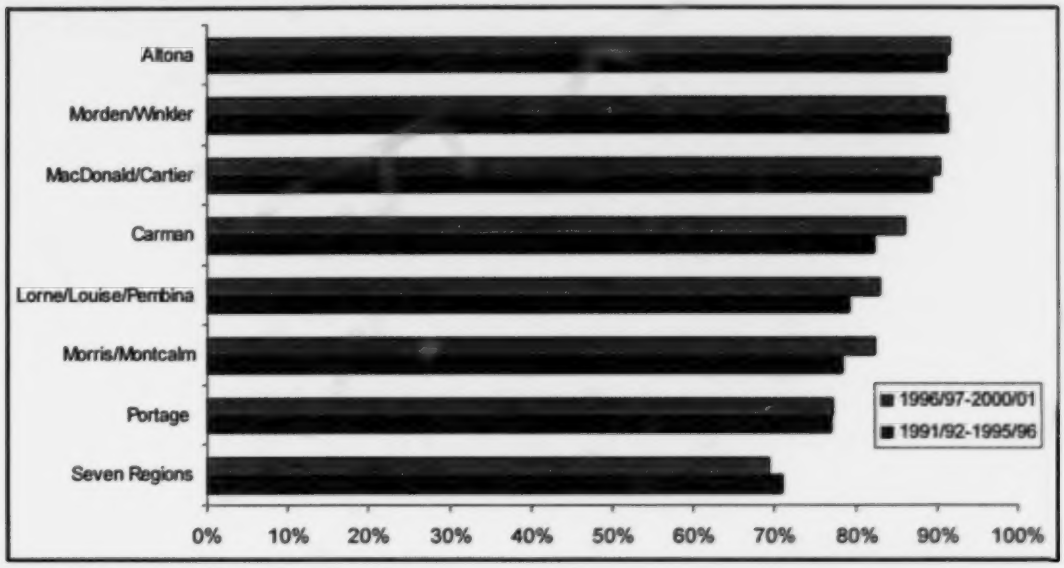
FIGURE 9. Changes in breastfeeding initiation rates by region.



Source: Manitoba Centre for Health Policy, Need to Know Project.

Within our Region, rates of breastfeeding initiation vary by area. Between 1996/97 and 2000/01 the highest rates were in Altona and Morden/Winkler – with both just over 90 per cent. The lowest rates were in Seven Regions (69%) and Portage (77%). It is important to note that the Areas with the highest teen pregnancy rates also have the lowest breastfeeding initiation rates. It would be interesting to pursue if there is a relationship as some research indicates that young mothers are less likely to breastfeed.

FIGURE 10. Breastfeeding initiation rates by RHA Central Area



Source: Manitoba Centre for Health Policy, Need to Know Project.

Performance Measure LOW BIRTH WEIGHT

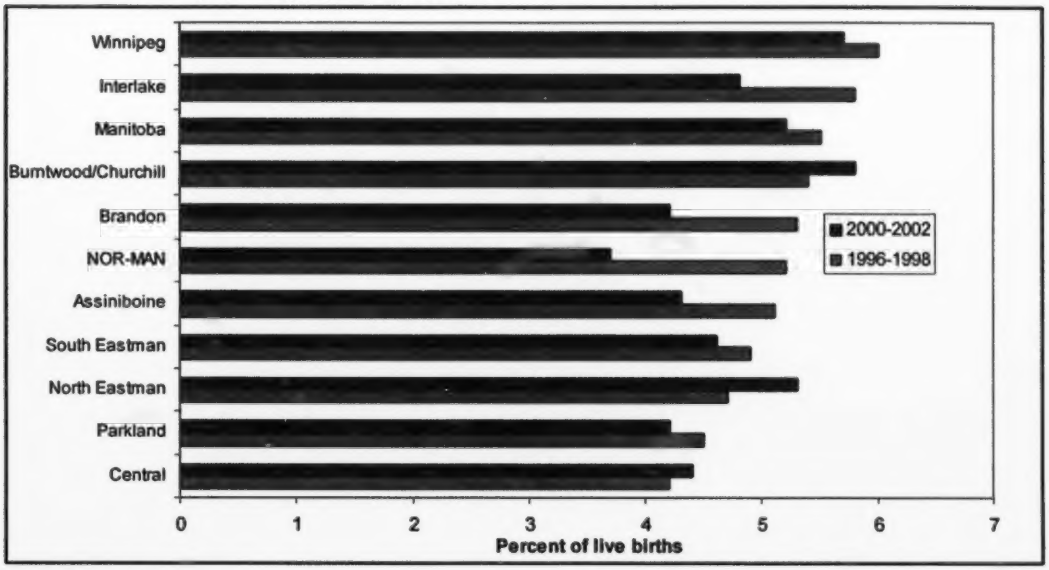
Significance of this Measure

Low birth weight is a key determinant of infant survival, health, and development. Low birth weight infants are at a greater risk of having a disability and for diseases such as cerebral palsy, visual problems, learning disabilities and respiratory problems.

Performance Highlights

Between 1996 and 1998, 4.2 per cent of live born infants in the Central Region were low birth weight. This means that these babies weighed less than 2500 grams. This was the lowest rate in the province. Our rate increased very slightly to 4.4 per cent between 2000 and 2002, however we are still well below the provincial average of 5.2 per cent (see FIGURE 11).

FIGURE 11. Low birth weight (<2500 grams) infants by region, 1996-1998 and 2000-2002



Source: Statistics Canada.

Performance Measure PHYSICAL ACTIVITY

Significance of this Measure

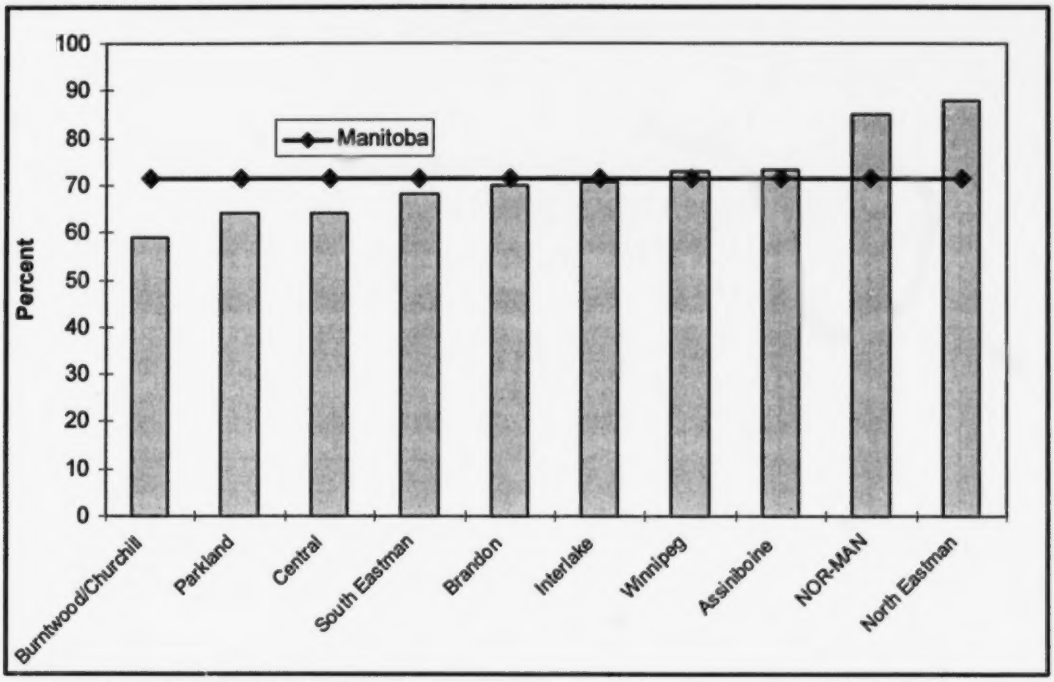
Most children enjoy physical activity, especially activities that they can do with their friends and which give them a feeling of accomplishment such as building snowman, skating or swimming. Many children are also involved in organized sports and other activities, like hockey, soccer, gymnastics, basketball and dance. However research is showing that there is a tendency for school-age children to spend more and more of their time in less active pursuits, like watching TV or playing computer/video games[v].

Research also shows that there is a relationship between physical activity and health eating habits. When children are active, they are more likely to feel good about themselves and to recognize when they are hungry and when they are full. This allows them to eat enough to meet their nutritional needs and have the energy they need to be active. Children who are hungry or who do not eat well are less likely to have enough energy to be active and to get involved in activities that will help them to feel good about themselves.

Performance Highlights

In Central Region, only 64.2 per cent of youth meet the criteria for being either "active" or "moderately" active. This is the third lowest rate in Manitoba (see FIGURE 12). In addition, within our Region, only 58.1 per cent of young females are either active or moderately active compared to 70 per cent of young males.

FIGURE 12. Proportion of youth age 12-19 who are active or moderately active, 2003.



Source: Canadian Community Health Survey Cycle 2.1 (2003).

Performance Measure NUTRITION

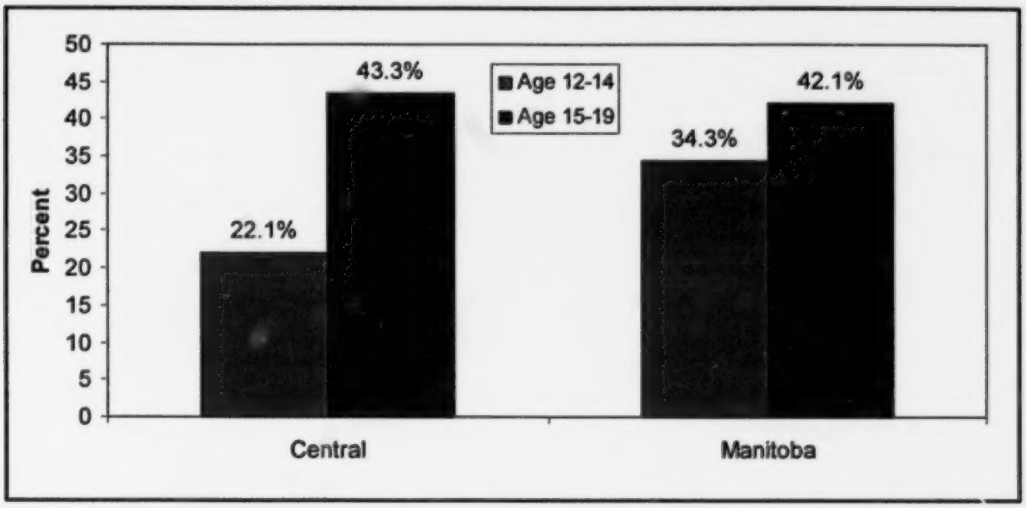
Significance of this Measure

Personal health practices, such as healthy eating, play a large part in determining how healthy people will be. Between about the ages of six and twelve, children are learning to make decisions and beginning to make more choices on their own. They are developing attitudes and habits that they will carry with them for the rest of their lives. It is important, therefore, that parents support children in making nutritious eating habits a part of their lives from very early ages.

Performance Highlights

In Central Region, just over one in five children age 12 to 14 eat at least five servings of fruits and vegetables daily (see FIGURE 13), this is lower than the provincial rate of 34.3 per cent. The rates increase among youth age 15 to 19 where 43.3 per cent consume five or more servings daily.

FIGURE 13. Proportion of youth age 12-19 who consume at least five servings of fruits and/or vegetables daily, 2003.



Source: Canadian Community Health Survey Cycle 2.1 (2003).

Performance Measure

EXPOSURE TO SECOND-HAND SMOKE (SHS) IN THE HOME

Significance of this Measure

Breathing in second-hand smoke causes over 1,000 deaths in Canadian non-smokers from lung cancer and heart disease every year[vi].

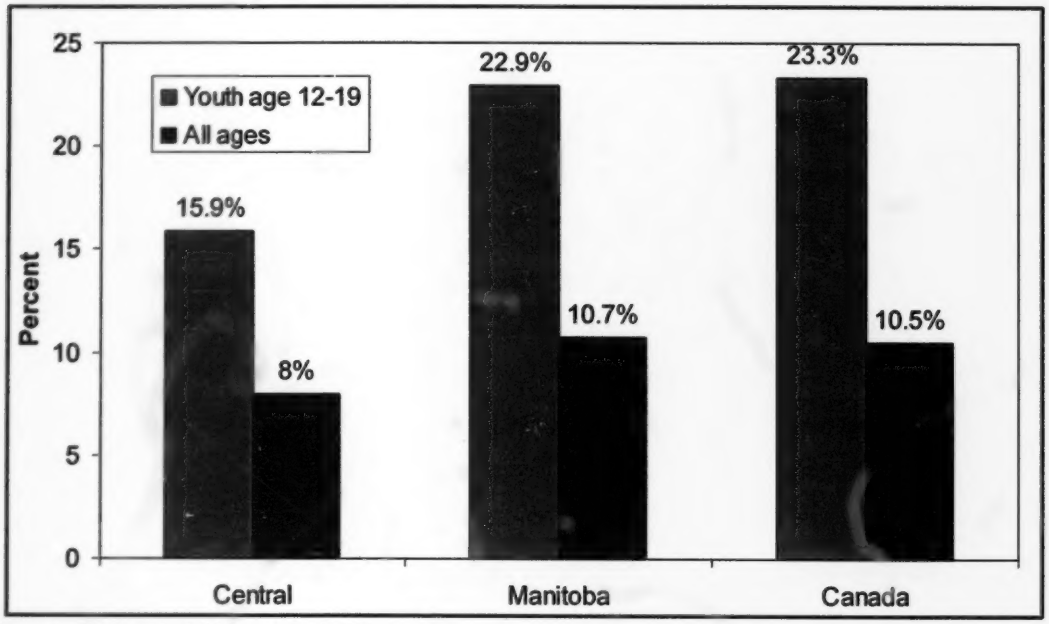
In 2003, almost one sixth (14%) of Canadian homes with children under 12 years old reported their children were exposed to second-hand smoke (SHS) from cigarettes, cigars or pipes. Although this number is dropping, it still means that about 600,000 children under age 12 continue to be exposed regularly to second-hand smoke[vii].

The good news is that most Canadian families agree they should avoid exposure to second-hand smoke in their home and car. Currently, four out of five (82%) Canadian homes already restrict smoking in some way.[viii] Parents also report that the primary reason they want to cut back on the amount of second-hand smoke in their home is because of their children.[ix]

Performance Highlights

FIGURE 14 illustrates a very important situation that children and youth continue to face in their own homes. While parents report that they are trying not to exposure their children to SHS, just over 15 per cent of youth age 12 to 19 are still exposed to SHS in their homes. Although this is lower than the rates reported for Manitoba and Canadian children (of approximately 23% in each case), the rates are still too high. It is also important to note that a higher proportion of our youth are exposed to SHS than the population overall. This is critical as it shows the lack of power and choice children have in where they live and what occurs in their environment. While adults can choose to live only with non-smokers and/or not allow smoking in their homes, children cannot make these choices.

FIGURE 14. Exposure to second hand smoke in the home, 2003.



Source: Canadian Community Health Survey Cycle 2.1 (2003).

Performance Measure READINESS TO LEARN

Significance of this Measure

There is growing evidence that early childhood experiences have significant long-term effects. What happens to children when they are very young shapes their health and wellbeing, including their capacity for life-long learning and overall success. "Readiness to learn" is a measure of many aspects of a child's development at age 5, a key developmental transition for most children. Being "ready to learn" includes: physical wellbeing and age-appropriate physical development (e.g., fine and gross motor skills); emotional health, including an ability to adapt to new experiences; age-appropriate social knowledge; language skills; and, general knowledge[x]. In Manitoba, Readiness to Learn is measured by the kindergarten teacher using the Early Development Instrument.

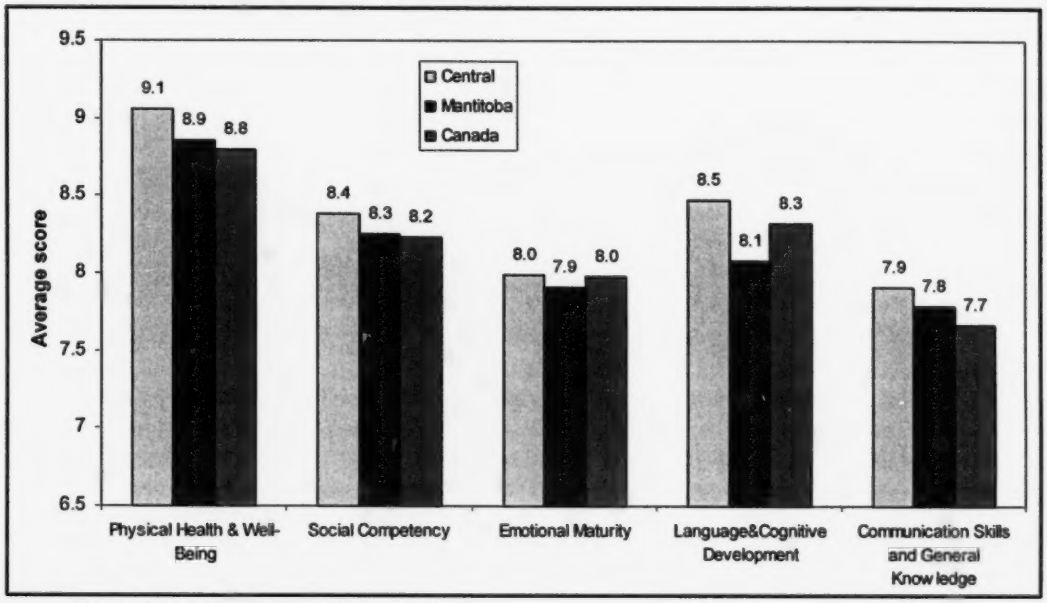
This measurement is a powerful predictor of a child's future wellbeing, including development of a child's sense of self-respect and concern for others, literacy and overall academic performance, propensity towards life-long learning, health status as an adult as well as anti-social and risk-taking behaviours[xi].

Performance Highlights

As FIGURE 15 illustrates, on each of the five measures of Readiness to Learn, kindergarten students in Central Region scored higher than students in Manitoba and in Canada. Overall, in 2003-04, 22.1 per cent of Central Region children in kindergarten were not

ready to learn in at least one of the five measures. This is significantly lower than the provincial average of 29.2 per cent of children. On the positive end of the scale, 56.3 per cent of our children are "very ready" to learn in at least one area when they start kindergarten compared to 51.8 per cent of Manitoba children. This difference is also statistically significant.

FIGURE 15. Early Development Instrument Results: Average Scores, 2003-04.



Source: Healthy Child Manitoba, Early Development Instrument Survey.

BOARD END ABORIGINALS, including First Nations, Métis and Inuit, are AS HEALTHY AS THEY CAN BE.

OUTCOMES

- Aboriginals live at least as long as other people in Central Region
  - Children and adolescents practice healthy lifestyle behaviours
  - Aboriginals will not die from complications of diabetes.
- Aboriginals have hope and pride and dignity
  - Aboriginals receive psychosocial support in situations that diminish their hope, pride and dignity.
- Aboriginals receive the services they need despite jurisdictional barriers
  - Aboriginals live in a healthy environment.
- Aboriginals receive culturally appropriate health care.

Performance Measures reported in 2003-04

In our 2003-04 Annual Report we presented information about the following performance measures related to Aboriginal people:

- Population profiles
- Premature Mortality Rates
- Potential Years of Life Lost
- Life Expectancy
- Injuries
- Diabetes

2004-05 Performance Measures

- Access to health services
- Health service utilization
  - Ambulatory physician visits
  - Hospitalizations
- Wellbeing
- Smoking
- Housing

Performance Measure ACCESS TO HEALTH SERVICES

Significance of this Measure

Health care accessibility is one of the principles of the *Canada Health Act*. This means that reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers. Accessibility can also be thought of more broadly, sometimes there are barriers beyond those identified by the Act that can impact the ability of some cultural groups to access health services. Aboriginal people have identified that access to health services is an issue that must be addressed.

Performance Highlights

During the 2004 focus group consultation process, transportation to health care services was identified as an issue impacting accessibility of our services. There was concern expressed about the funding formula for First Nations communities that includes money for some non-insured health services and for transportation to access health services. It was expressed that the cost for transportation to services was higher than their budget would allow. As an example, within our First Nations communities there has been an increased incidence of clients requiring dialysis and the increased transportation costs associated with this is of concern.

Common concerns around accessing services were often related to physician services. Specifically, participants spoke of difficulty in obtaining a permanent family physician and charges for missed appointments. While access to physician services is of concern in many areas, we heard a new concern related to cost. We were told of termination of services and waiting times to be seen in emergency. For example, if a person misses an appointment at certain clinics without prior notification, regardless of the reason, there is a charge for the missed appointment, with a consequence of discontinued services until the charge is paid. We were told that one exception to discontinued service is for prenatal care. We were told of many reasons for missed appointments without notification including lack of transportation.

Performance Measure

HEALTH SERVICE UTILIZATION INCLUDING AMBULATORY PHYSICIAN VISITS AND HOSPITALIZATIONS

Significance of this Measure

The perception expressed through the Community Health Assessment focus groups was that it was difficult for First Nations residents (especially those living on reserve) to access health services. It is important to also review utilization data to determine if there appears to be a lower than expected rate of physician and hospital service utilization among this group. This measure is also important to review so that we can determine where our Aboriginal population is receiving health care and work together on the development of culturally-appropriate services both at the community and acute care level.

Performance Highlights

An ambulatory, or "walk-in" visit is any contact with a physician that occurs while the client is not a hospital in-patient. Visits in physician offices, personal care homes, emergency rooms of hospitals, and outpatient departments are all included within ambulatory visits.

The most recent information available about physician and hospital visits among First Nations people is for the years 1998/99. In Central Region the ambulatory physician visit rate was 6.72 visits per person compared to 4.02 visits among all other regional residents. This difference between the two groups is statistically significant. The physician visit rate is almost the same among First Nations living on-reserve (6.65 visits per person) as for First Nations residents living off-reserve (6.81 visits per person).

For hospitalizations we can look at numbers of hospitalizations, days spent in hospital and location of the hospitalization. Within our Region the hospitalization rate among First Nations people is 2.3 times the rate for all other residents. This is partly due to the higher rates of some diseases (such as diabetes) that can require hospitalization but it is also due to the higher birth rates (most of which take place in hospital) among First Nations residents. When First Nations residents are hospitalized, the average stay is 2.17 days which is almost twice the length of stay of all other residents at 1.11 days per hospital stay. The length of hospitalization is slightly higher among First Nations who live on-reserve at 2.3 days compared 2.05 days for First Nations residents who live off-reserve.

When First Nations people are hospitalized, just over three-quarters of the hospitalizations were accommodated in the Region (compared to 64.2% of all other residents) – that is they were able to receive their care in the Region and closer to home. The majority of

hospitalizations outside of Central Region occur in Winnipeg – 18.6 per cent of First Nations hospitalizations compared to 30 per cent of hospitalizations for other residents.

Performance Measure MENTAL HEALTH AND WELLBEING

Significance of this Measure

Our wellbeing is impacted by more than our physical health. Mental health is a crucial dimension of overall health and an essential resource for living. It influences how we feel, perceive, think, communicate and understand. Without good mental health, people can be unable to fulfill their full potential or play an active part in everyday life. Mental health issues can address many areas, from enhancing our emotional wellbeing, treating and preventing severe mental illness to the prevention of suicide.

Performance Highlights

In 2004, as part of our Comprehensive Community Health Assessment, focus groups were conducted with many groups of people. A local telephone survey was also commissioned with Acumen research. There were focus groups with three of the First Nations communities at this time. Because there is very little data collected at a regional level about our Aboriginal residents, we would like to present some of the information that was collected through our focus groups and survey about the issue of wellbeing.

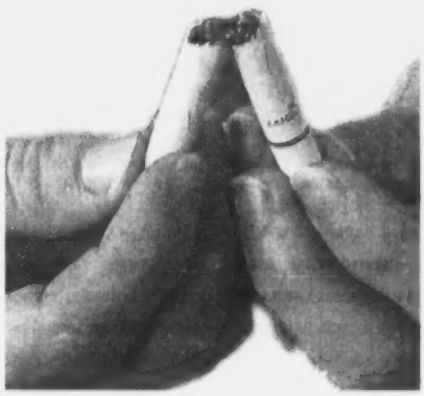
During the focus group discussions, issues related to mental health and wellbeing were identified as major concerns. There was a consensus among focus group participants that mental health issues needed to be addressed in order to improve the health outcomes of this population. Feelings of hopelessness and helplessness affect how the population values their overall health. These negative feelings, in some instances, have led to behaviours such as alcoholism, drug abuse and gambling. Some participants discussed root causes of these problems. For example it was suggested that current Mental Health problems stem from decisions made in the 1960s permitting "drinking in bars" and, secondly, as a result of the introduction of the welfare system during the same era.

A frequent sentiment in the focus group discussions was that issues with mental health have resulted from collective experiences such as the Residential School System. In addition, data from our telephone survey showed that those of First Nation/Aboriginal/Métis ancestry were more likely than the general population to report recent emotional difficulties. At a provincial level, the Manitoba First Nations Regional Health Survey of 1998, reported that 31 per cent of the population surveyed report having suicidal feelings, and 13 per cent indicated that they had actually attempted suicide.

Performance Measure SMOKING

Significance of this Measure

Given the negative health effects of smoking, there is a need for everyone to reduce the rate of tobacco use in order to reduce smoking related illness and death. While tobacco plays a significant ceremonial role in the traditions of Aboriginal people it is clear that cigarette smoking is a health concern, unrelated to the ceremonial aspects of life. According to figures from the Canadian Paediatric Society, "...men and women on reserve have a 40 per cent higher rate of stroke and a 60 per cent higher rate of heart disease than other Canadians." A large number of these health outcomes are likely related to smoking.



Performance Highlights

Although we do not have smoking data at a regional level for our Aboriginal residents, provincial level data indicates that smoking is a major concern among Aboriginal people. According to the Manitoba Centre for Health Policy, 64 per cent of First Nations people in Manitoba currently smoke, 21 per cent began before age 14 years and 67 per cent before age 15 years.

Performance Measure HOUSING

Significance of this Measure

A shortage of adequate housing and crowding that can lead to life stresses and other poor health outcomes. People who live in overcrowded, cold, and/or unsanitary housing are much more likely to develop illnesses, take longer to recover and to pass on communicable diseases such as tuberculosis. In addition, children who live in over crowded homes where they are exposed to large amounts of second hand smoke, are at a much higher risk of developing otitis media (ear infections).

Performance Highlights

Although we do not have data specific to Central Region, we can learn from the provincial level data that has been published. According to the Manitoba Centre for Health Policy First Nations Survey of 2002, 84 per cent of First Nations living on reserve live in band housing. Housing conditions on reserve have been identified as being worse than in Winnipeg, with 41 per cent requiring major repairs. The average number of persons per housing unit for First Nations people is twice that of the overall population of Manitoba (4.8 versus 2.6). Problems with overcrowding exist. Crowding is partly a factor of family size, and partly of housing cost and supply. Ten per cent of Aboriginal people live in housing with two or more persons per bedroom. Although housing construction has increased on reserve, conditions and suitability remain concerns.

BOARD END WOMEN are AS HEALTHY AS THEY CAN BE.

OUTCOMES

- Women have safe living and working conditions
  - Women are free from violence
  - Women have sufficient financial resources
- Women have good reproductive health
- Women are supported in their care-giving role.

In our 2003-04 Annual Report we presented information about the following performance measures related to women:

- Wellbeing
- Mortality
- Injuries
- Morbidity
  - Diabetes
  - Hypertension
  - Cancer
- Weight and physical activity
- Smoking
- Breast screening
- Cervical screening
- Income.

2004-05 Performance Measures

- Updated breast and cervical screening
- Breast cancer mortality
- Birth by caesarean section
- Violence.

Performance Measure

UPDATED BREAST AND CERVICAL SCREENING RATES

Significance of this Measure

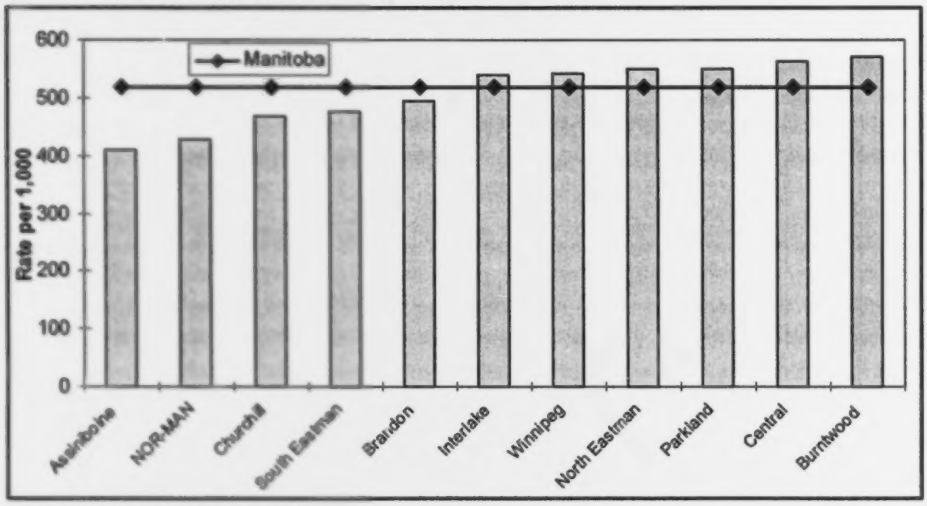
Early detection of breast cancer leads to more effective treatment and can save lives. Studies show that breast X-rays, taken on a regular basis, have the potential to reduce deaths from breast cancer for women by up to 40 per cent. The target age group for breast cancer screening is 50 to 69. Women can have mammograms if they are not in this age range and it is usually because they have exhibited a risk factor (such as family history) or they have found a suspicious lump.

Cervical cancer is a very important disease because it is highly treatable when detected. With proper screening, death rates from cervical cancer can be nearly eradicated altogether. At a minimum, it is recommended that all women age 18 to 69 have a pap test annually. However, others recommend that screening should occur at the onset of sexual activity (regardless of age) and continue well into old age.

Performance Highlights

Between April, 2001 and March of 2003, RHA Central mammography screening rates were higher than the provincial average in every age group. Between 2003 and 2005, the trend of higher screening rates continued (see FIGURE 16) with Central Region screening rate of 562.8 per 1,000 compared to the provincial rate of 518.6 per 1,000.

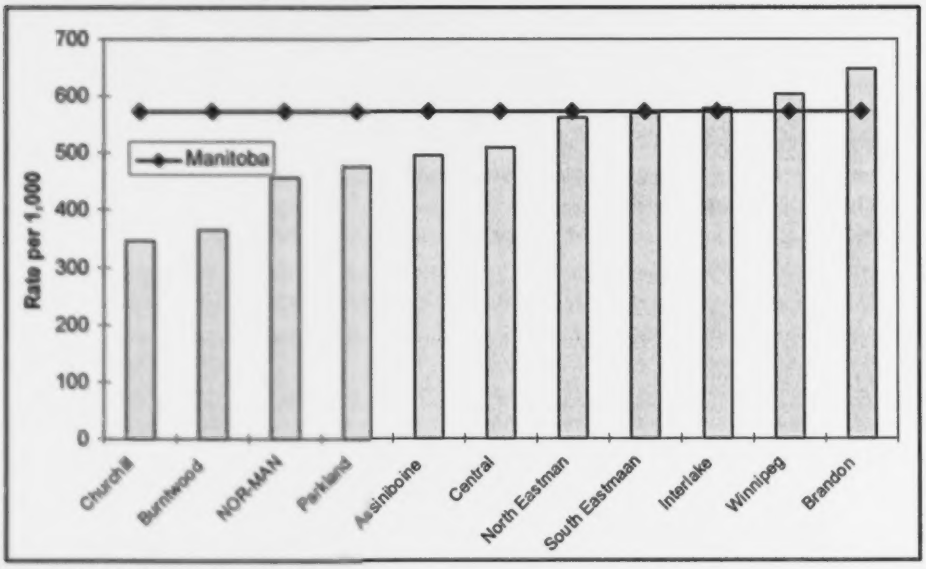
FIGURE 16. Breast cancer screening rate for women age 50 to 69, 2003-2005.



Source: Manitoba Health, Decision Support Services.

Between 2000 and 2003, 52 per cent of women were screened at least once for cervical cancer. This has decreased slightly to a rate of 508.6 per 1,000 or, just under 51 per cent of the female population. As FIGURE 17 illustrates, not only has our screening rate dropped slightly, we are also below the provincial average screening rate.

FIGURE 17. Cervical cancer screening rate, 2003-2005.



Source: Manitoba Health, Decision Support Services.

Performance Measure BREAST CANCER MORTALITY

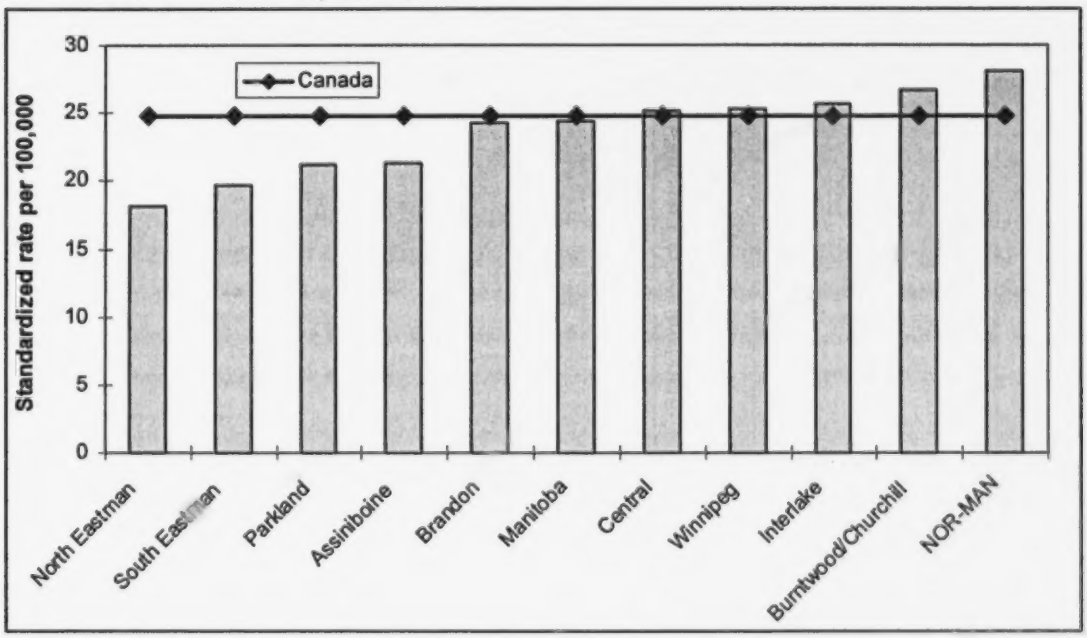
Significance of this Measure

Breast cancer is one of the most common forms of cancer in women. In Central Region, breast cancer is the most frequently diagnosed cancer among women. While the causes of breast cancer are not fully understood, research shows that you can lower your risk of developing the disease or dying from it, by minimizing lifestyle and environmental risk factors and through breast cancer screening.

Performance Highlights

Although Central Region has the second highest rate of breast cancer screening, the standardized death rate due to breast cancer was slightly higher than the province between 2000 and 2002 (See FIGURE 18). The mortality rate in our Region is 25.2 deaths per 100,000 which is higher than both the provincial (24.4 deaths per 100,000) and Canadian rates (24.8 deaths per 100,000)

FIGURE 18. Standardized breast cancer mortality rates, 2000-2002.



Source: Statistics Canada.

Performance Measure BIRTH BY CAESAREAN SECTION

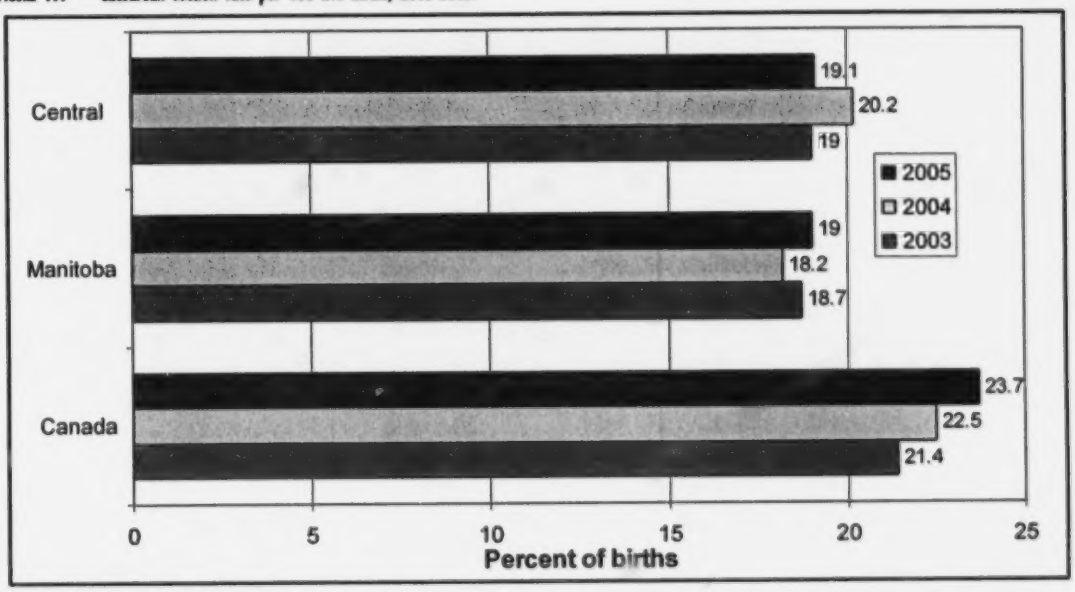
Significance of this Measure

Caesarean birth is an important indicator because it carries greater risk for both the mother and baby. A caesarean birth also takes longer to recover from than a vaginal birth. Once mom and baby leave the hospital, some moms must be readmitted to hospital. In the case of caesarean births, the readmission rate is higher than for vaginal delivery, and this rate has increased while readmission after vaginal delivery has remained stable.[xii] It is possible that rates of maternal readmission after Caesarean birth are being exacerbated as postpartum stays in hospital become shorter.

Performance Highlights

Between 2003 and 2005, the caesarean section in Central Region and Manitoba remained relatively stable at approximately one in five births. This is lower than the Canadian rates in the same time period (see FIGURE 19).

FIGURE 19. Caesarean section rate per 100 live births, 2003-2005.



Source:Canadian Institute for Health Information.

Performance Measure VIOLENCE

Significance of this Measure

There is a social and financial cost associated with violence against women. Violence against women increases costs in health, social services, criminal justice (estimated around $1.5 billion) and in employment through lost working days. Although all women are vulnerable to violence in society, immigrant and refugee women, Aboriginal women, young and senior women are at particular risk.

Central Region has a significant population of women at risk for violence by this description. We have an elderly population of 14 per cent of our population, 56 per cent of whom are women. We have a high proportion of immigrants, particularly the Low German Speaking Mennonites from Mexico (Kanadier Mennonites) and we have a relatively high Aboriginal population, approximately 50 per cent of whom are female. Being a victim of violence is linked with a number of health consequences for women: addictions, mental illness, migraine headaches, eating disorders, arthritis, irritable bowel syndrome, reproductive health problems like chronic pelvic pain, sexually transmitted disease and death.

Performance Highlights

Injury from an outside source, that is, violence or assault, is less common for women than injury from themselves or than assault upon men. However, women have died from assault in Central Region and they have been hospitalized, without death, at the rate of 25.9/100,000 versus 71/100,000 for men in the years from 1992-2001.

BOARD END MEN are AS HEALTHY AS THEY CAN BE.

OUTCOMES

- Men do not suffer or die from preventable injuries
  - Men will make informed choices related to high-risk activities
- Men will have good mental health
- Men are free from addictions
- Men are educated and employed to their full potential
- Men will access services when they need them.

In our 2003-04 Annual Report we presented information about the following performance measures related to men:

- Mortality
- Injury
- Chronic diseases
- Wellbeing
- Body mass index
- Smoking
- Physical activity
- Life stress
- Workplace injuries.

2004-05 Performance Measures

- Education
- Employment and income
- Injury mortality compared to other Canadian men
- Health care utilization
  - Physician visits
  - Dental visits
  - Alternative health care provider visits.

Performance Measure EDUCATION

Significance of this Measure

There is a known link between higher educational attainment, higher socioeconomic status, and better health. In particular, achieving less than a highschool graduation is a factor that tends to limit employment choices and earning potential.

Performance Highlights

As can be seen in TABLE 1, a large proportion of men in Central Region have less than high school education. We can see that a higher proportion of males appear to be completing high school than in the past since there is a trend toward more high school education in our younger aged men. However, the reverse trend appears to be true for post-secondary education with a higher proportion of our older generation of men having achieved this status. The problem with respect to interpretation is that young people, such as 20-year olds, will still be in university so that older men will have had time to finish school and would be counted while the very young men have not. The men aged 35-44, however, are most likely to have completed their education and a lower percentage have post secondary education than the 65+ generation.

TABLE 1. Educational Achievement, RHA Central males, 2001.

Age Group	Less than high school graduation (% of population)	University certificate, diploma or degree (% of population)
20-34	37.7	11.5
35-44	40.7	11.2
45-64	48.8	15.5

Source: Statistics Canada, 2001 Community Profiles.

Performance Measure

EMPLOYMENT AND INCOME

Significance of this Measure

Research shows that health status improves at each step up the income and social hierarchy. Living on low income creates uncertainty, insecurity, and a feeling of lack of control over one's life, all of which have powerful effects on health.

Performance Highlights

According to the 2001 Census, men working full time earned on average, $34,200.

As TABLE 2 illustrates, labour force participation rates are much higher among Central Region males than females. TABLE 3 illustrates that although more women than men participate in unpaid work, men do account for 48 per cent of unpaid work. However, men are less likely to participate in looking after children and giving assistance to seniors than they are to do unpaid housework.

TABLE 2. Central RHA labour force indicators by sex, 2001.

Labor Force Indicators	Total	Male	Female
Participation rate	67.8	76.0	59.8
Employment rate	64.9	72.9	57.0
Unemployment rate	4.3	4.1	4.7

Source: Statistics Canada, 2001 Community Profiles.

TABLE 3. Unpaid work characteristics, by Sex, Central RHA 2001.

	Total	Male	Female
Persons reporting hours of unpaid work	65,995	31,760	34,235
Persons reporting hours of unpaid housework	65,230	31,200	34,025
Persons reporting hours looking after children, without pay	31,200	13,905	17,300
Persons reporting hours of unpaid care or assistance to seniors	17,540	7,295	10,240

Source: Statistics Canada, 2001 Community Profiles.

Men in the Central Region reported lower earnings than men on average in Manitoba (see TABLE 4). The average income for all working men in 2001 in the Central RHA was $27,513 compared to $32,312 in Manitoba overall. Just over 61 per cent of males working in the Region worked full time for the whole year in 2001. Of those, the average income was higher at $34,200 but the gap between the Region and the province is even larger for this group, where the provincial average income of men working full time for the full year was $41,027.

TABLE 4. Earning Statistics, Central RHA and Manitoba, 2001.

Characteristics	RHA – Central Manitoba Inc.			Manitoba		
	Total	Male	Female	Total	Male	Female
Earnings						
All persons with earnings (counts)	48,925	26,460	22,465	609,575	320,670	288,900
Average earnings (all persons with earnings ($))	23,277	27,513	18,288	27,178	32,312	21,480
Worked full year, full time (counts)	25,505	16,280	9,225	331,655	195,760	135,895
Average earnings (worked full year, full time ($))	31,327	34,200	26,257	36,549	41,027	30,099

Source: Statistics Canada, 2001 Community Profiles.

Performance Measure INJURY MORTALITY

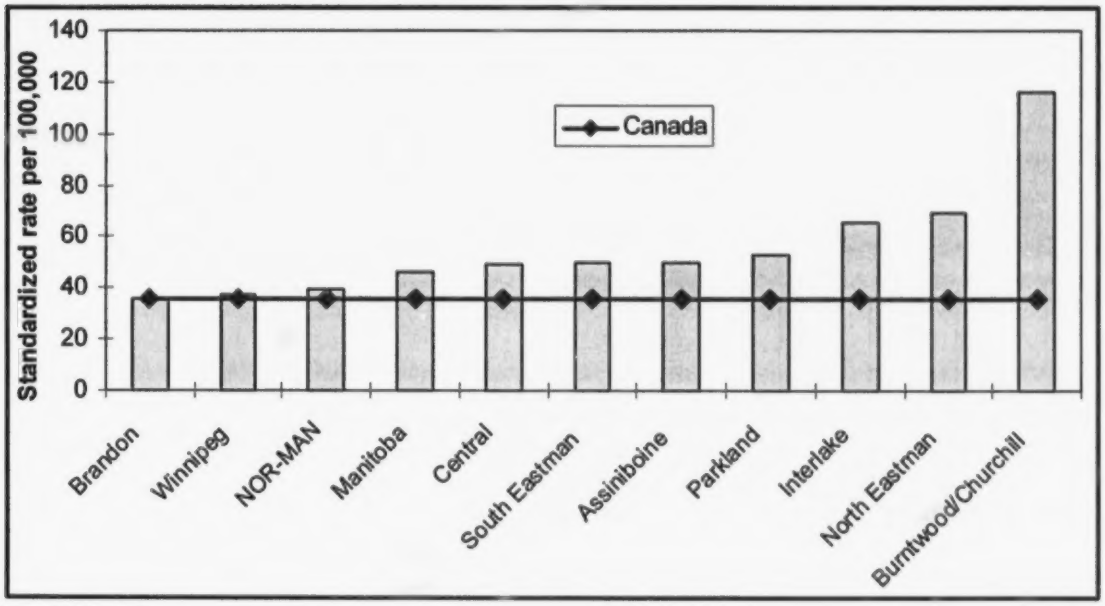
Significance of this Measure

Unintentional injury mortality rates are an important cause of death among men, particularly young men.

Performance Highlights

Looking at men specifically, we can see that our death rate due to unintentional injury is higher than both the provincial and Canadian averages (see FIGURE 20).

FIGURE 20. Standardized unintentional injury mortality rate, males, 2000-2002.



Source: Statistics Canada.

Performance Measure HEALTH CARE UTILIZATION

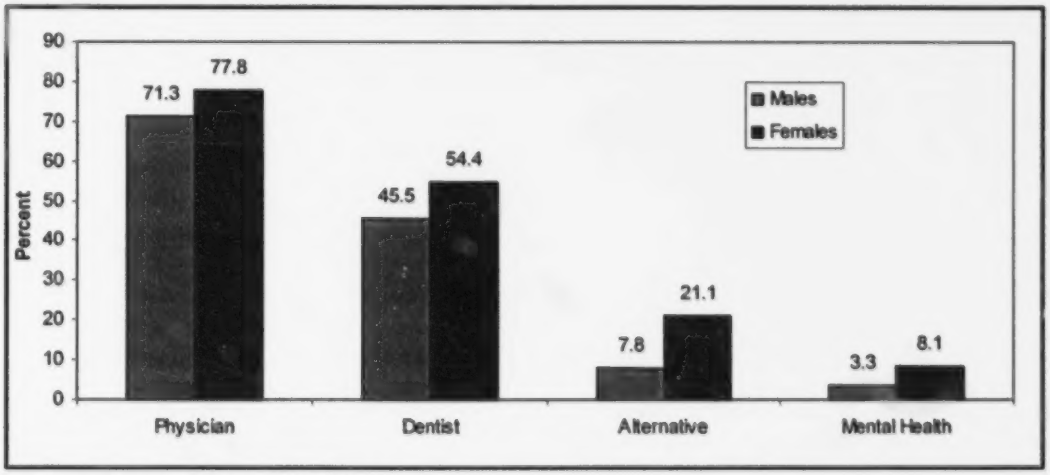
Significance of this Measure

Although men tend to die at younger ages, and therefore, are obviously subject to at least as many health problems as women, research shows that in general, women tend to access treatment more readily than men. Although health services is not the only determinant of good health, it is one of them. Visiting our doctor or other health professional can assist us in diagnosing diseases before they become serious, in helping with management of chronic conditions and in helping us maintain positive mental health.

Performance Highlights

Fewer men than women have contact with health professionals in every category we examined (see FIGURE 21). For example, according to the 2003 Canadian Community Health Survey, 71 per cent of men (age 12 and older) visited a physician within a 12-month period compared to 78 per cent of women. The difference is even greater when looking at contact with a health professional for a mental health related issue. In this case, only 3.3 per cent of men report visiting a health professional compared to 8.1 per cent of women. Alternative health care providers include massage therapists, acupuncturists, homeopaths or naturopaths, spiritual healers, religious healers, etc. Again we can see that men are much less likely to seek out services than are women.

FIGURE 21. Contact with medical professionals, Central Region males and females, 2003.



Source: Canadian Community Health Survey, Cycle 2.1 (2003).

BOARD END SENIORS are AS HEALTHY AS THEY CAN BE.

OUTCOMES

- Seniors remain independent and active as long as possible
- Seniors experience an optimal quality of life
  - Seniors are free from abuse
- Seniors live in their community of choice
  - Seniors utilize housing appropriate to their needs
- Seniors have support in their care-giving role
- Seniors receive respect and appropriate care from their children and/or their community.

In our 2003-04 Annual Report we presented information about the following performance measures related to seniors:

- Living arrangements
- Self-report health
- Disability-free life expectancy
- Injuries
- Diabetes
- Arthritis/rheumatism
- Hypertension
- Functional health status
- Nutrition
- Physical activity limitations
- Immunization
- Depression
- Personal care home and home care use.

2004-05 Performance Measures

- Chronic pain
- Physical activity
- Life stress.

Performance Measure CHRONIC PAIN

Significance of this Measure

Chronic pain can significantly interfere with our quality of life as well as our ability to live independently.

Performance Highlights

According to the first cycle of the Canadian Community Health Survey, 15.8 per cent of seniors living in private households in our Region experience chronic pain that is severe enough to prevent either some or all activities. It is important to note that this survey is a private household surveys only. Therefore, these numbers likely under-represent the true rates in the population as those seniors with a very severe activity limitation do to chronic pain or health problems may not be able to stay in their home.

Performance Measure PHYSICAL ACTIVITY

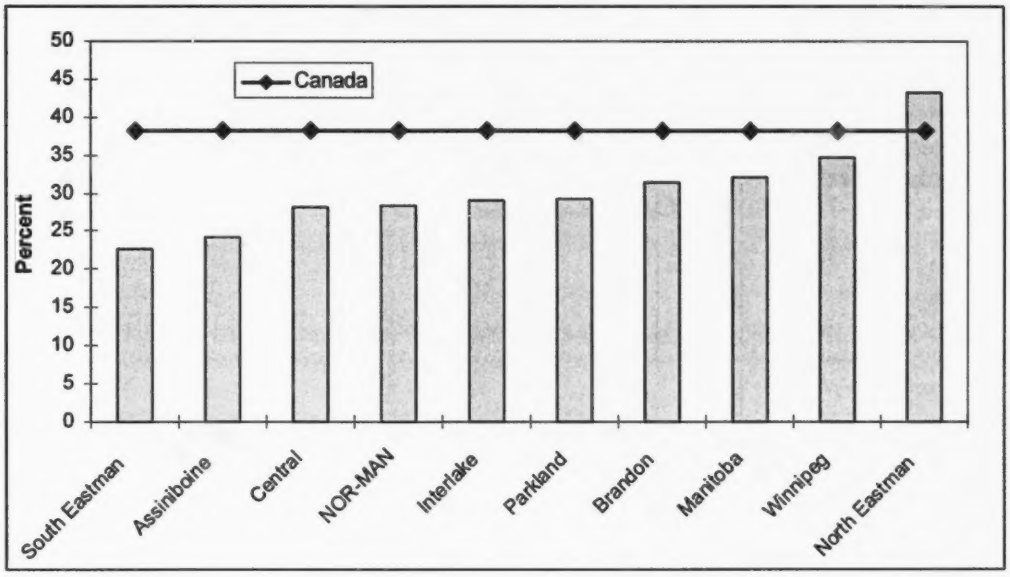
Significance of this Measure

Physical activity provides seniors with the opportunity to get out and get active with friends and family. It is the best way to stay healthy both physically and mentally.

Performance Highlights

Seniors living in Central Region have the third lowest activity rate in the province (see FIGURE 22). Just over one in four people age 65 and older are physically active in our Region. This is lower than both the Manitoba and Canada averages of 32.2 and 38.2 per cent respectively. Our ability to exercise is impacted by the weather conditions and proximity to facilities. In our Region, seniors in rural areas may be having difficulty in accessing suitable exercise programs and facilities.

FIGURE 22. Proportion of seniors (age 65+) who are active or moderately active, 2003.



Source: Canadian Community Health Survey, Cycle 2.1 (2003).

Performance Measure LIFE STRESS

Significance of this Measure

We all have stress in our lives. However, inappropriately handled stress can be devastating. It lowers our resistance and makes us more vulnerable to illness and disease. Increased and/or ongoing stress can cause our health to deteriorate resulting in a variety of serious physical problems. People with a lot of life stress can become physiologically old and run down long before their time.

Performance Highlights

In our Region, 56.8 per cent of seniors (age 65+) indicate that they have "some" life stress. A further 13.8 per cent indicate that they have "quite a lot" of life stress.

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[i] Health Canada News Release, August 2005. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_94_e.html

[ii] World Health Organization (WHO). Protecting, promoting and supporting breastfeeding: the special role of maternity services. Geneva: A Joint WHO/UNICEF Statement; 1989

[iii] Canadian Pediatrics Society, Dietitians of Canada, Health Canada. Statement on nutrition for healthy term infants. Ottawa: Health Canada Communications

[iv] Breastfeeding Committee for Canada. Breastfeeding statement of the Breastfeeding Committee for Canada

[v] Canada's Food Guide - Focus on Children 6-12 years -Background for Educators and Communicators. http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/res/focus_child-focaliser_enfant_e.html

[vi] Health Canada News Release, November 2003.

[vii] Health Canada. (2003) Canadian Tobacco Use Monitoring Survey (CTUMS). Ottawa.

[viii] Health Canada. (2003) Canadian Tobacco Use Monitoring Survey (CTUMS). Ottawa.

[ix] EKOS, Phoenix Strategic Perspectives Inc. Baseline Survey of Parents on Second-hand Smoke in the Car and at Home. Report to Health Canada, March 2004, p. i.

[x] Background information on measuring readiness to learn announced in the speech from the throne September 23, 1997. http://socialunion.gc.ca/nca/nca5_e.html

[xi] Ibid.

[xii] Chalmers, B, Wen, Shi Wu (2000). Perinatal Care in Canada, Women's Health Surveillance Report.

FINANCIAL STATEMENTS

STATEMENT OF FINANCIAL POSITION

	2005	2004
ASSETS		
CURRENT		
Cash and short term investments	$ 10,236,990	$ 10,392,672
Accounts receivable, net	1,194,474	1,433,458
Accounts receivable - Manitoba Health	522,748	1,040,261
Inventories	1,118,926	1,000,762
Prepaid expenses	409,724	487,412
Due from Manitoba Health - vacation entitlements	7,775,928	7,775,928
NON-CURRENT		
Due from Manitoba Health - retirement entitlements	9,106,000	9,106,000
Capital assets	82,164,448	84,107,177
Other assets	149,093	150,340
	$ 112,678,331	$ 115,494,010
LIABILITIES, DEFERRED CONTRIBUTIONS AND NET ASSETS		
CURRENT		
Accounts payable and accrued liabilities	$ 8,868,944	$ 8,440,739
Accrued vacation entitlements	8,366,206	7,775,928
Current portion of long term debt	772,200	771,400
	18,007,350	16,988,067
NON-CURRENT		
Accrued retirement entitlements	8,966,900	9,106,000
Long term debt	10,799,379	11,275,230
	19,766,279	20,381,230
DEFERRED CONTRIBUTIONS		
Expenses of future periods	2,734,987	3,162,292
Capital assets	69,302,873	70,906,897
	72,037,860	74,069,189
NET ASSETS		
Invested in capital assets	1,345,868	1,209,525
Contract facilities	1,095,308	1,233,305
Internally restricted	276,773	277,531
Unrestricted	148,893	1,335,163
	2,866,842	4,055,524
COMMITMENTS AND CONTINGENCIES		
	$ 112,678,331	$ 115,494,010

STATEMENT OF OPERATIONS

	2005	2004
REVENUE		
Manitoba Health	$ 126,489,126	$ 119,540,771
Other government departments	1,570,307	1,257,159
Non-global patient and resident income	11,182,184	10,951,177
Other income	4,923,761	4,423,318
Amortization of deferred contributions - operating	129,791	307,556
Amortization of deferred contributions - capital and foundations	5,257,854	4,971,014
Interest and donations	296,689	396,979
Ancillary operations	2,131,360	2,218,050
	151,981,072	144,066,024
EXPENSES		
Acute care services	51,491,041	48,013,132
Long term care services	41,138,748	39,418,457
Medical remuneration	10,342,028	10,086,678
Community based therapy services	1,497,976	1,382,935
Community based mental health services	7,437,055	6,971,498
Community based home care services	14,031,757	13,466,163
Community based health services	5,780,764	5,336,456
Land ambulance	4,671,751	4,029,593
Regional health authority undistributed	8,176,790	6,794,573
Interest on long term debt	398,173	438,849
Pre-retirement leave	944,278	799,380
Amortization of capital assets	4,564,407	4,751,960
Major repairs	640,056	305,014
Capital Grants	200,000	-
Donations to foundations	22,000	54,104
Ancillary operations	1,862,930	2,040,035
OPERATING EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	(1,188,682)	177,197
OTHER INCOME (EXPENSE)		
Sale of capital assets	-	5,385
	-	5,385
EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES	$ 1,188,682	$ 182,582
ALLOCATION OF EXCESS (DEFICIENCY) OF REVENUE OVER EXPENSES		
Capital and donations to foundations	$ (168,609)	$ (134,679)
Interest and donations	296,689	396,979
Ancillary operations	268,430	178,015
Prior years' funding adjustments	695,786	648
Health care operations	(2,280,978)	(258,381)
TOTAL	$ (1,188,682)	$ 182,582

Regional Health Authority
Central Manitoba Inc.

Office régional de la santé
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